

10467 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>Fort Howard</u>		<u>2 yrs 9 days</u>		TOWN <u>Baltimore</u> <u>3yrs 1-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1379 Whatcoat Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>AUGUSTUS</u> <u>ABRAMS</u>				DATE OF DEATH: <u>November 27</u> <u>1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Negro</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>8/11/96</u>	
9. AGE last birthday: <u>59 years</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		IF UNDER 24 HRS.	
		Months		Days		Hours	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Apartment House</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Joe Abrams</u>				14. MOTHER'S MAIDEN NAME: <u>Mary E. Queen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO. <u>218-87-8200</u>			
17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>150X CARCINOMA OF ESOPHAGUS</u>						<u>18 Months</u>	
ANTECEDENT CAUSE (B): DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>002X</u>							
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>PULMONARY TUBERCULOSIS</u>						UNKNOWN	
19A. DATE OF OPERATION: <u>9/13/54</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Transitional squamous Carcinoma of Esophagus</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 18, 1953</u> , to <u>Nov. 27, 1955</u> , and that death occurred at <u>12:20 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>James J. Nolan, M.D.</u>				ADDRESS <u>Fort Howard, Md.</u>		DATE SIGNED <u>11/27/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-30-55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11-25-55</u>		REGISTRAR'S SIGNATURE <u>L</u>		24. FUNERAL DIRECTOR <u>George Kelson</u>		ADDRESS <u>1348 N. Calhoun St. Baltimore, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO
LIBRARY
540 EAST 57TH STREET
CHICAGO, ILL. 60637

INSTRUCTIONS

1 The law requires that the death certificate be executed within **24 hours** after death.

The bottom copy may be retained by the hospital or attending physician.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10459

10461 CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Md.</u> COUNTY <u>Balto.</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Halethorpe</u>		LENGTH OF STAY (In this place) <u>31 yrs</u>		CITY OR TOWN <u>Halethorpe</u>		CITY OR TOWN <u>51</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5726 First Ave</u>		STREET ADDRESS (If rural give location) <u>5726 First Ave</u>		STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED				4. DATE OF DEATH			
(First) <u>ARTHUR</u>		(Middle) <u>L.</u>		(Last) <u>ADAMS SR.</u>		(Date) <u>Nov. 12</u> (Year) <u>19 55</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 29, 1893</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brush finisher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pitts. plate glass.</u>		11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Adams</u>				14. MOTHER'S MAIDEN NAME <u>Maria.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>217-01-4327</u>		17. INFORMANT & ADDRESS <u>Arthur L. Adams, 5726 First Ave</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				48 Hours			
357X IMMEDIATE CAUSE (A) <u>Hypostatic Bronchopneumonia (Bilat.)</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Sclerosis of the spinal cord</u>				26 Months			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>Dec 1942</u>		19b. MAJOR FINDINGS OF OPERATION <u>sclerosis of thoracic portion of spinal cord</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 5, 1953</u> to <u>Nov 12, 1955</u> , that I last saw the deceased alive on <u>9-12, 1955</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Nathan Racusin</u>				ADDRESS (Street, city, town, state) <u>M.D. 206 S Gilmer ST.</u>		DATE SIGNED <u>11-14-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 16/55</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Dr. Geo. M. Zuff</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witzke</u>		ADDRESS <u>101 Edmondson Ave.</u>	
DATE <u>Nov. 14, 1955</u>							

10452

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1941 CERTIFICATE OF DEATH

BUREAU V. 2

RECEIVED

EXHIBIT

RECEIVED
MAY 10 1950
U.S. DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
WASHINGTON, D.C.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10468 CERTIFICATE OF DEATH

10460

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Holbrook</u>		<u>30 years</u>		TOWN <u>Holbrook</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Randallstown P.O.</u>				STREET ADDRESS (If rural give location) <u>Randallstown P.O.</u>			
3. NAME OF DECEASED (Type or Print) <u>Elizabeth Van Huse Allen</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 9 1955</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Oct. 23, 1874</u>	
9. AGE last birthday <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edgar Van Huse</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Schermuhoorn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. O. T. Gosnell - Granite, Md.</u>	
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
163X IMMEDIATE CAUSE (A) <u>Carcinoma of Large Intestine</u>				INTERVAL BETWEEN ONSET AND DEATH <u>?</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardio-vascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Bronchial asthma</u>							
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>11/9/55</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/3</u> , 19 <u>55</u> , to <u>11/9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/9</u> , 19 <u>55</u> , and that death occurred at <u>6:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wm. E. Marten</u>				ADDRESS (Street, city, town, state) <u>M.D. Randallstown</u>		DATE SIGNED <u>11/11/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-12-55</u>		NAME OF CEMETERY OR CREMATORY <u>Ward's Chapel</u>		LOCATION (City, town, or county) <u>Baltimore Co., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Wm. E. Marten</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Hight</u>		ADDRESS <u>Chesapeake, Md.</u>	
DATE <u>11/11/55</u>							

10488

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

10488 CERTIFICATE OF DEATH

MASSACHUSETTS

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Date of death: _____
6. Place of death: _____
7. Cause of death: _____
8. Signature of physician: _____
9. Signature of registrar: _____
10. Signature of informant: _____

BUREAU V. 2

NOV 14 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

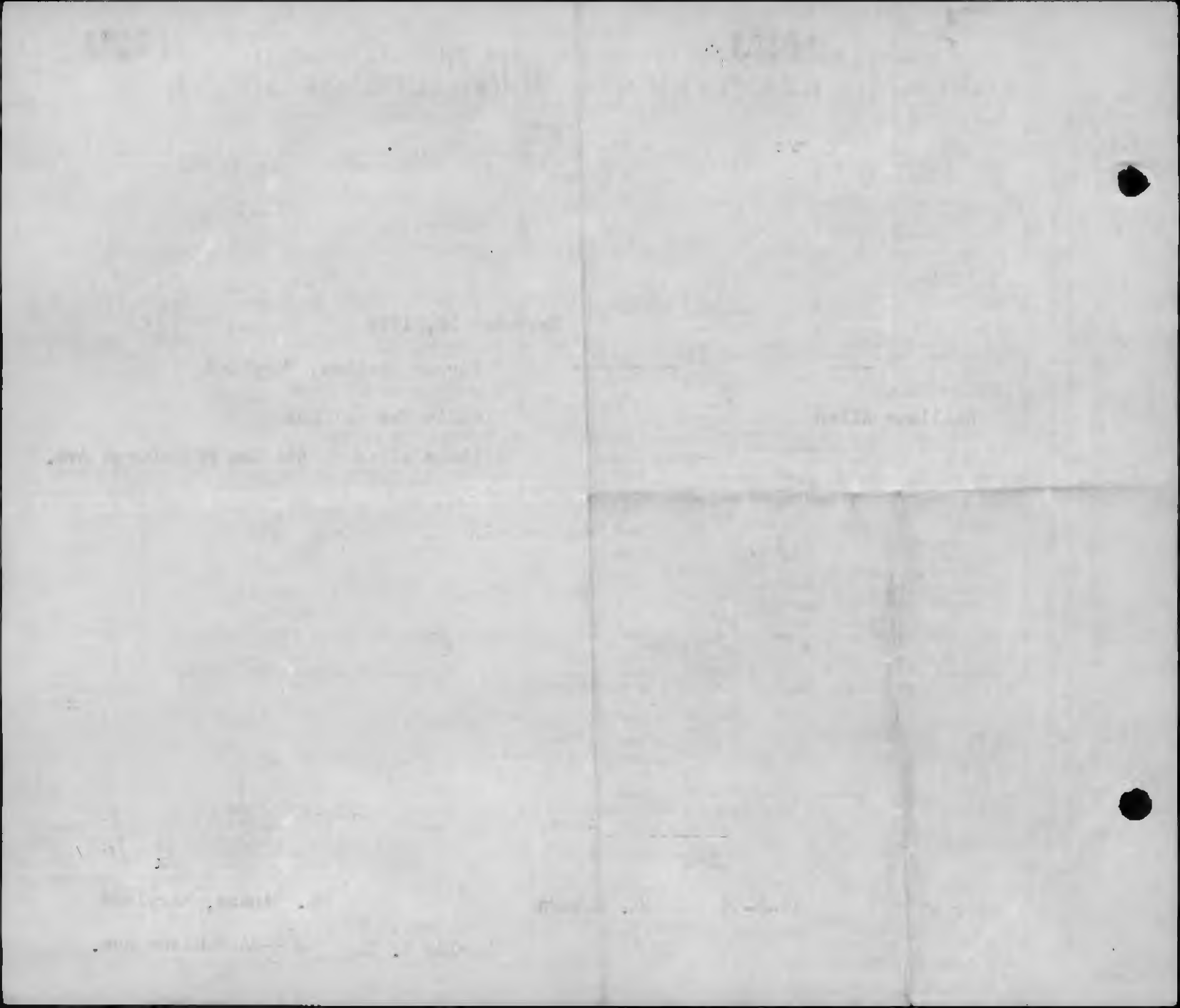
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10461
Reg. Dist.

No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Dundalk</u>				TOWN <u>Dundalk</u>		<u>53</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>554 New Pittsburgh Avenue</u>				STREET ADDRESS (If rural, give location) <u>554 New Pittsburgh Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>RICHARD</u> <u>ALLEN</u>				<u>11</u> <u>30</u> <u>19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE Last birthday: yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
<u>Male</u>	<u>Colored</u>		<u>November 26, 1955</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):			10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
					<u>Turner Station, Maryland</u>		
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Zellious Allen</u>				<u>Lealie Mae Collins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
(If Yes, give war or dates of service)				<u>Zellious Allen</u> <u>554 New Pittsburgh Ave.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>770.1</u> Immediate cause (a) <u>Erythroblastosis with kernicterus</u> DUE TO Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) _____ DUE TO							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>William W. Smith</u>		<u>12-2-55</u>		<u>Mt. Auburn</u>		<u>Mt. Winans, Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE REC'D BY LOCAL REG.		24. FUNERAL DIRECTOR		ADDRESS	
<u>Burial</u>		<u>12/4/55</u>		<u>Charles R. Law</u>		<u>802-04 Madison Ave.</u>	

1045303404



10469 CERTIFICATE OF DEATH

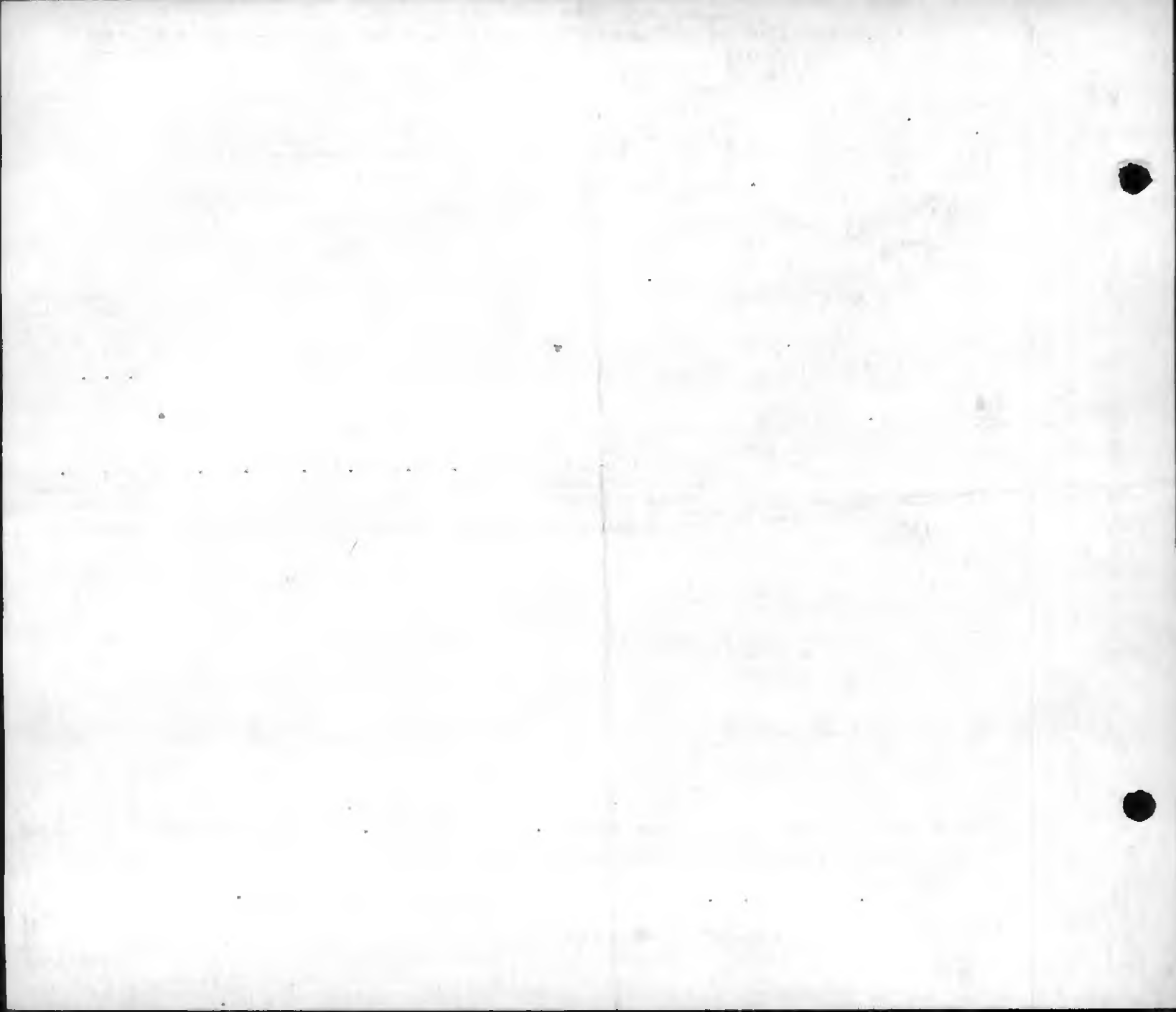
Reg. Dist. No. 10469

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> <u>3401.4</u>			
X TOWN <u>Fort Howard, Md.</u>		<u>8 days</u>					
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>806 North Point Road</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>November 26 19 55</u>			
<u>ROBERT C. ALLEN</u>							
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>8/21/89</u>	9. AGE last birthday: <u>66</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Iron Worker</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Iron & Steel Industry</u>		11. BIRTHPLACE (State or foreign country): <u>Macon, Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Arthur T. Allen</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Fell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO.: <u>217-05-8429</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>ACUTE MYOCARDIAL INFARCTION</u>						1 WEEK	
ANTECEDENT CAUSE (B) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>						UNKNOWN	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 18, 19 55</u> to <u>Nov. 26, 19 55</u> , that I last saw the deceased <u>known to me</u> and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>James J. Nolan</u>		ADDRESS <u>M. D. VAH, Fort Howard, Md.</u>		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-30-55</u>		NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11-24-55</u>		REGISTRAR'S SIGNATURE <u>L</u>		24. FUNERAL DIRECTOR <u>Ullrich Funeral Home, 2112 Dundalk Ave.</u>		ADDRESS <u>Baltimore, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH
10470 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

10463

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>Balto Co</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore Md</u> 3-01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Rt. 40</u>		STREET ADDRESS (If rural, give location) <u>806 Wicklow Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>HOWARD KELLY BAKER</u>		4. DATE OF DEATH (Month) <u>11</u> (Day) <u>11</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>12/12/98</u>
9. AGE last birthday <u>56</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>E. Cockman Baker</u>		14. MOTHER'S MAIDEN NAME <u>Ada Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>E. Cockman Baker</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
<p>776X Immediate cause (a) Gunshot wound through roof of mouth producing penetrating wound of skull & brain. (No wound of exit)</p> <p>Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)</p>		Instantaneous
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Nov. 11, '55 10a.m.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Self-inflicted</u>
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .		
SIGNATURE <u>Dr. H. G. Gath</u> M.D. Asst. Physician		DATE SIGNED <u>11 Nov. '55</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>U.S. National</u>
DATE REC'D BY LOCAL REG. <u>11-14-55</u>	REGISTRAR'S SIGNATURE <u>T. E. Harry</u>	LOCATION (City, town, or county) (State) <u>Balto Md</u>
24. FUNERAL DIRECTOR <u>McDonald & Son</u>		ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A



10471 **CERTIFICATE OF DEATH**

10464

Reg. Dist. No. 14

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort Howard</u>		<u>12 Hours</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>2012 Pulaski Street</u>			
3. NAME OF DECEASED (Type or Print) <u>WILLIAM H. BALL</u>				4. DATE OF DEATH (Month) <u>November</u> (Day) <u>16</u> (Year) <u>19 55</u>			
5. SEX <u>Male</u>	6. CO. OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>7/26/92</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fish business</u>		11. BIRTHPLACE (State or foreign country) <u>Lancaster County, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Alfred Ball</u>				14. MOTHER'S MAIDEN NAME <u>Louise Cox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
1. IMMEDIATE CAUSE (A) <u>CHRONIC CYSTITIS; PYO-HYDRONEPHROSIS; ABSCESES</u>						INTERVAL BETWEEN ONSET AND DEATH	
2. ANTECEDENT CAUSE(S) (B) <u>OF KIDNEYS</u>						UNKNOWN	
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 15 1:45 P.M.</u> to <u>Nov. 16 1:45 A.M.</u> and that death occurred at <u>1:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William B. VanDeGrieff, M.D.</u>				ADDRESS (Street, city, town, state) <u>M.D. VAH, FORT HOWARD, MARYLAND</u>			
DATE SIGNED <u>11-17-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>11/20/55</u>		NAME OF CEMETERY OR CREMATORY <u>Ball Family Cemetery</u>		LOCATION (City, town, or county) (State) <u>Merry Point, Lancaster Co. Va.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Sawson L. Farley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>		ADDRESS <u>802-04 Madison Ave. Baltimore 1, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

Shipped to

WINKER Funeral Home, Lancaster, Virginia

101.

1177

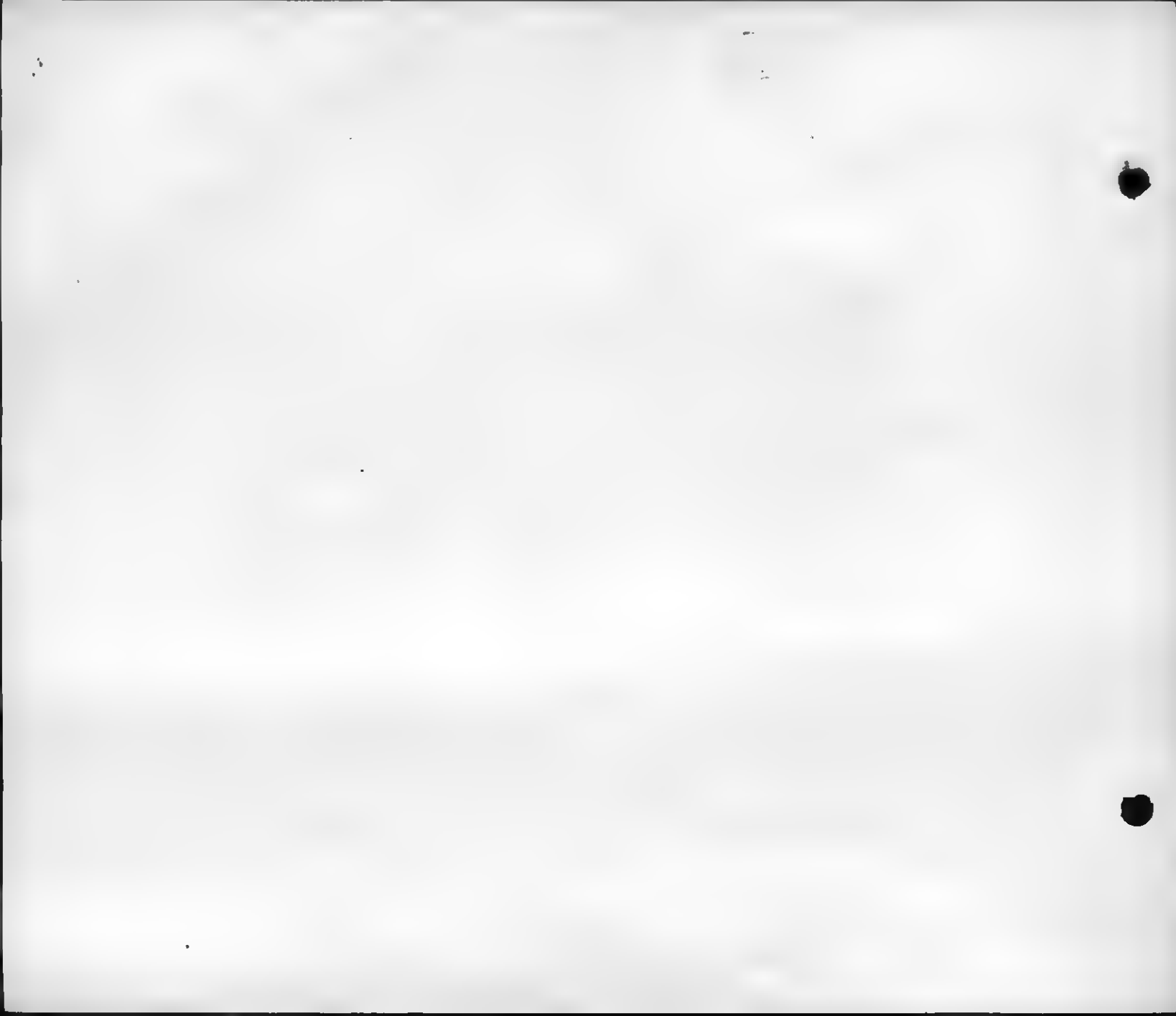
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10472 CERTIFICATE OF DEATH

Reg. Dist. No. 10465

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Larchmont</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2501 Birch Drive</u>				STREET ADDRESS (If rural give location) <u>2501 Birch Drive</u>			
3. NAME OF DECEASED: (First) <u>GEORGE</u> (Middle) <u>W.</u> (Last) <u>BARRANGER</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Nov. 29, 19 55</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Jan. 2, 1897</u>	9. AGE last birthday: <u>58</u> yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>retired Owner Package Goods Store</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Herbert Barranger</u>				14. MOTHER'S MAIDEN NAME: <u>Annie Smallwood</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mr. George H. Barranger p 2501 Birch Drive</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage (3rd)</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 1/2 hrs.</u>			
ANTECEDENT CAUSE (B) <u>Hypertension + Obesity</u>				<u>x yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 19 55</u> to <u>Nov 29 19 55</u> that I last saw the deceased alive on <u>11-29-</u> , 19 <u>55</u> , and that death occurred at <u>P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>G. B. Embor</u>				DATE SIGNED <u>7201 York Rd. Balto. Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>12/2/55</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12 2 55</u>				REGISTRAR'S SIGNATURE <u>G. H. Haight</u>		24. FUNERAL DIRECTOR <u>Wm. J. Vickers & Sons - Balto 17 Md</u>	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10473 CERTIFICATE OF DEATH

10466

Reg. Dist. No. 39

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
OR TOWN <u>Phoenix (Rural)</u>		LENGTH OF STAY (In this place) <u>life</u>		OR TOWN <u>Phoenix (Rural)</u>		OR TOWN <u>Phoenix (Rural)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Paper Mill Rd.</u>				STREET ADDRESS (If rural give location) <u>Paper Mill Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Nearmon</u>		(Middle) <u>Elbert</u>		(Last) <u>Barrett</u>		<u>11-9-55</u> 19 <u>55</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>2-23-1887</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Barrett</u>				14. MOTHER'S MAIDEN NAME <u>Cecelia Grice</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs. Pearl B. Barrett, Phoenix, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
177X IMMEDIATE CAUSE (A) <u>Carcinoma of Prostate</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) <u>-</u>							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/31/1955</u> to <u>11/9/1955</u> that I last saw the deceased alive on <u>11/8/1955</u> and that death occurred at <u>2:25 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>M. X. Quinn</u> M.D.				DATE SIGNED <u>1927 York Rd, TIMONICUM Md 11/10/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-12-55</u>		NAME OF CEMETERY OR CREMATORY <u>Poplar Grove</u>		LOCATION (City, town, or county) (State) <u>Cockeysville, Md.</u>	
24. REC'D BY REGISTRAR <u>Nov 13 1955</u>		REGISTRAR'S SIGNATURE <u>M. Elizabeth Gorauch</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Scott Brooks</u>		ADDRESS <u>Shonks, Md.</u>	



10474 CERTIFICATE OF DEATH

Reg. Dist. No.

32

1. PLACE OF DEATH <i>Mt. Wilson St. Hosp.</i>		2. USUAL RESIDENCE (HOME) OF DECEASED: <i>Md. Baltimore</i>	
COUNTY <i>Mt. Wilson</i>	MARYLAND	STATE	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) <i>TOWN</i>	LENGTH OF STAY (in this place) <i>16 months</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore 24</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Mt. Wilson</i>		STREET ADDRESS (If rural give location) <i>2820 Hudson St</i>	
3. NAME OF DECEASED: (Type or Print) <i>Rudolph</i>		4. DATE (Month) (Day) (Year) DEATH: <i>11 17 1955</i>	
(First) (Middle) (Last)			
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, (MARRIED), WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH: <i>4.13.1879</i>
9. AGE last birthday: <i>76</i> yrs		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Metal Worker</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Shippin' Store Co.</i>	
11. BIRTHPLACE (State or foreign country): <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <i>Antoni Balogowski</i>		14. MOTHER'S MAIDEN NAME: <i>Josefa Horawski</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-01-5353</i>	
17. INFORMANT & ADDRESS: <i>Mt. Wilson State Hosp. Hosp. Records, Mt. Wilson, Md.</i>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <i>002X</i>		(A) <i>Far advanced pulmonary tuberculosis</i>	
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <i>cardiac insufficiency</i>	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION. <i>no</i>		19B. MAJOR FINDINGS OF OPERATION <i>no</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>7:00</i> , 1955, to <i>11.17.1955</i> ; that I last saw the deceased alive on <i>11.17</i> , 1955, and that death occurred at <i>8:15 AM</i> , from the causes and on the date stated above.			
SIGNATURE <i>William M. D.</i>		ADDRESS <i>Mt. Wilson St. Hosp.</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>11.21.55</i>	
NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i>		LOCATION (City, town, or county) (State) <i>Belair Rd. Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>11-18-55</i>		REGISTRAR'S SIGNATURE <i>G. L. H. H. H.</i>	
24. FUNERAL DIRECTOR <i>John J. Duda</i>		ADDRESS <i>2829 Hudson St.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



10475

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Owings Mills P.O.		Life		TOWN Owings Mills P.O. X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer Park Road				STREET ADDRESS (If rural give location) Deer Park Road			
3. NAME OF DECEASED: (First) John (Middle) Thomas (Last) Baxter				4. DATE (Month) (Day) (Year) OF DEATH: Nov. 1, 1955			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): Married		8. DATE OF BIRTH: June 30, 1896	
9. AGE last birthday: 59 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer		10b. KIND OF BUSINESS OR INDUSTRY: Farm- Etc.		11. BIRTHPLACE (State or foreign country): Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME: George M. Baxter			
14. MOTHER'S MAIDEN NAME: Sarah Mitilda McGowan				15. INFORMANT & ADDRESS: Loretta Baxter, Deer Park Rd.			
16. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unk.): No (If Yes, give year or dates of service): No				17. SOCIAL SECURITY NO. 218-03-9326			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				IMMEDIATE CAUSE (A) Cardiac decompensation			
ANTECEDENT CAUSE (B) Cardio-vascular disease				DUE TO (B) Cardio-vascular disease			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21c. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1952 , 19...., to 11/1/55 , that I last saw the deceased alive on 11/1/55 , 1955, and that death occurred at 11 P. M, from the causes and on the date stated above.							
SIGNATURE John E. Martin		ADDRESS M.D. Poadelstown, Md		DATE SIGNED 11/2/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 11/3/55		NAME OF CEMETERY OR CREMATORY Holy Family		LOCATION (City, town, or county) (State) Harrisonville, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE John E. Martin		24. FUNERAL DIRECTOR		ADDRESS Frank H. Newell, Pikesville, Md.	

MARGIN RESERVED FOR BINDING



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10476 CERTIFICATE OF DEATH

10469

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place) <u>6 mos. 10 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>				STREET ADDRESS (If rural give location) <u>110 Conduit Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Edward</u> (First) <u>Beavin</u> (Middle) <u></u> (Last)				4. DATE OF DEATH (Month) <u>November</u> (Day) <u>16</u> (Year) <u>19</u> <u>55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>8-7-1870</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unknown</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Records Spring Grove State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Terminal Pneumonia</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u></u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-6-</u> <u>19</u> <u>55</u> , to <u>11-16-</u> <u>19</u> <u>55</u> , that I last saw the deceased alive on <u>11-16-</u> <u>19</u> <u>55</u> , and that death occurred at <u>9:00A</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Suea Wachler</u>				DATE SIGNED <u>11-16-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>				24. REC'D BY REGISTRAR <u>Victor E. Barry</u>			
DATE THEREOF <u>11/19/55</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>			
NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>				LOCATION (City, town, or county) <u>Annapolis, Md.</u>			
24. REC'D BY REGISTRAR <u>Victor E. Barry</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>			
DATE				ADDRESS <u>Annapolis, Md.</u>			



10477 CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Owings Mills</u>		<u>16 yrs.</u>		TOWN <u>Baltimore</u>		<u>3V11-1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rosewood Training School</u>				STREET ADDRESS (If rural give location) <u>1707 E. Baltimore Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Robert (Gott) Birdsong</u>				<u>11 6 19 55</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>		8. DATE OF BIRTH: <u>2/11/33</u>	
9. AGE last birthday: <u>22</u> yrs.		10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>--</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Jake Birdsong</u>				14. MOTHER'S MAIDEN NAME: <u>Bertha Gott</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>--</u>		16. SOCIAL SECURITY No.: <u>--</u>		17. INFORMANT & ADDRESS: <u>Rosewood Records</u>			

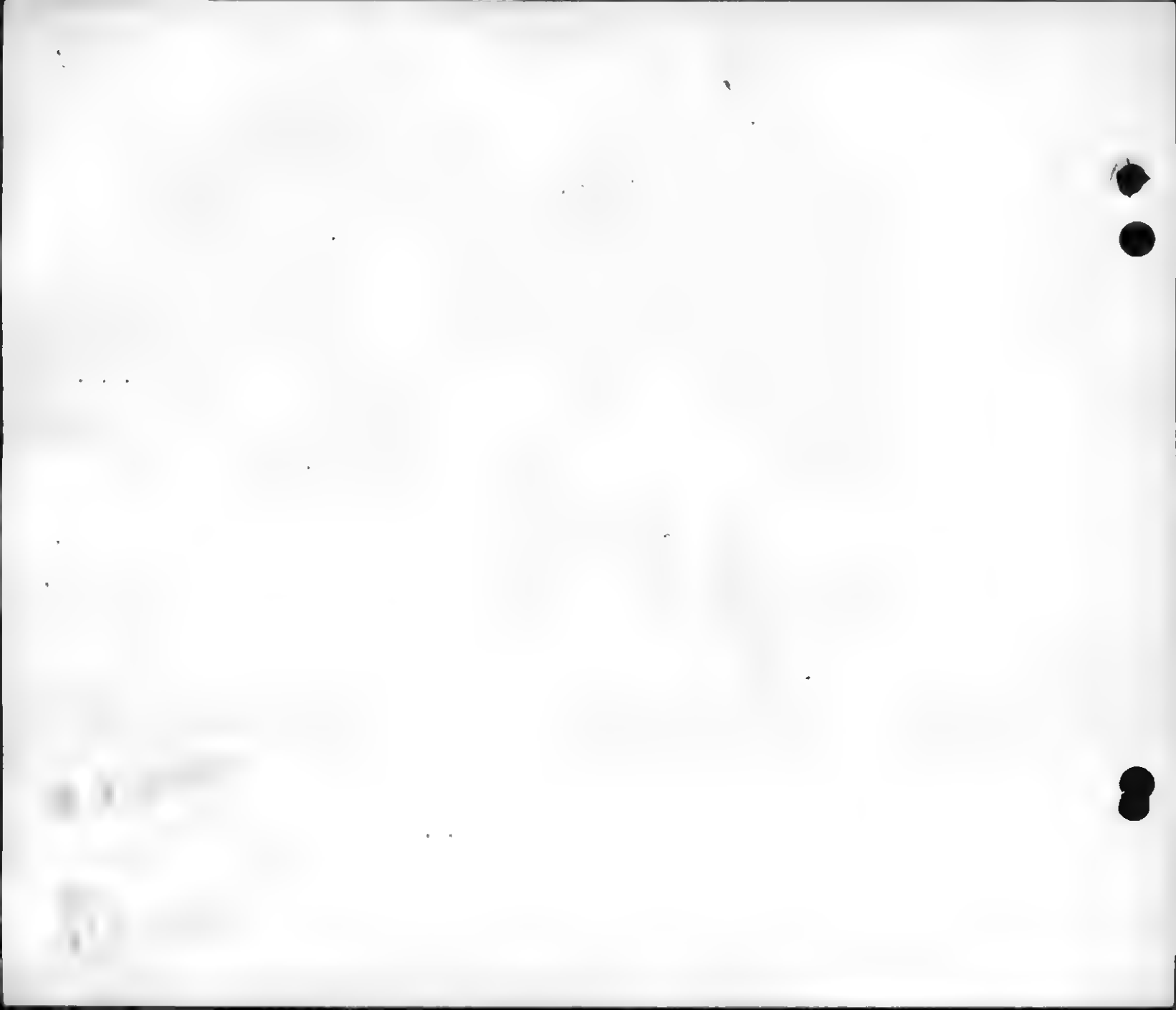
18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<u>500x</u>		
Immediate cause (a) <u>Acute Bronchitis</u>		<u>3 wks.</u>
DUE TO		
Antecedent cause(s) (b) <u>Broncho-Pneumonia</u>		<u>3 days.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO		
(c) <u>Spastic Paraplegia-Bed patient</u>		<u>Birth</u>

11. OTHER SIGNIFICANT CONDITIONS		20. AUTOPSY ?	
Conditions contributing to the death but not related to the disease or condition causing death.		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
SUICIDE		INJURY	
HOMICIDE		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR ?			

22. I hereby certify that I attended the deceased from <u>11/4</u> , 19 <u>55</u> , to <u>11/6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/6</u> , 19 <u>55</u> , and that death occurred at <u>5:40 P.m.</u> , from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>James S. Butler MD.</u>		<u>Owings Mills, Md. 9 Nov 55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	
<u>REMOVAL</u>		<u>NOV 10 - 55</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>UPDM MEDICAL SCHOOL</u>		<u>29 GREENE ST MD.</u>	
DAYS RECD BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
<u>Nov. 14, 1955</u>		<u>Diffel Blvd. 1800 E LOMBARD ST.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10471

CERTIFICATE OF DEATH

Reg. Dist. No.

Item 12. Film 189 12-5-55 et

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Baltimore</u> COUNTY <u>1</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Arbutus</u> LENGTH OF STAY (In this place) <u>1 1/2</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Arbutus</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>4210 Maryland Place</u>			
3. NAME OF DECEASED (Type or Print)		(First) <u>Blaschk</u> (Middle) <u>Blaschk</u> (Last) <u>Blaschk</u>		4. DATE OF DEATH		(Month) <u>Nov.</u> (Day) <u>10</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 2, 1898</u>	9. AGE last birthday <u>57</u> yrs.	If under 1 year Months Days	If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Continental Can Co</u>		11. BIRTHPLACE (State or foreign country) <u>Vienna, Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>Ludwig Blaschek</u>				14. MOTHER'S MAIDEN NAME <u>Sidonie Spiegel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>				16. SOCIAL SECURITY No.		17. INFORMANT <u>Marie S. Blaschek 4210 Maryland Place</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
443X Immediate cause (a) <u>Cerebral Hemorrhage</u>						<u>?</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Hypertensive Cerebrovascular disease</u>						<u>11/10</u>	
(c) _____							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT (Specify) SUICIDE HOMICIDE				PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>10-10</u> , 19 <u>55</u> , to <u>11-26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11-13</u> , 19 <u>55</u> , and that death occurred at <u>7:50</u> a.m., from the causes and on the date stated above.							
SIGNATURE <u>Earl Paso</u>				ADDRESS <u>4001 W. E. Avenue</u>		DATE SIGNED <u>11/27/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>11/29/55</u>		NAME OF CEMETERY OR CREMATORY <u>Meadowridge Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Dorsey, Md</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE <u>H. W. Weaver</u>		24. FUNERAL DIRECTOR <u>H. W. Weaver</u>		ADDRESS <u>805 N. Calvert St</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAIN INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

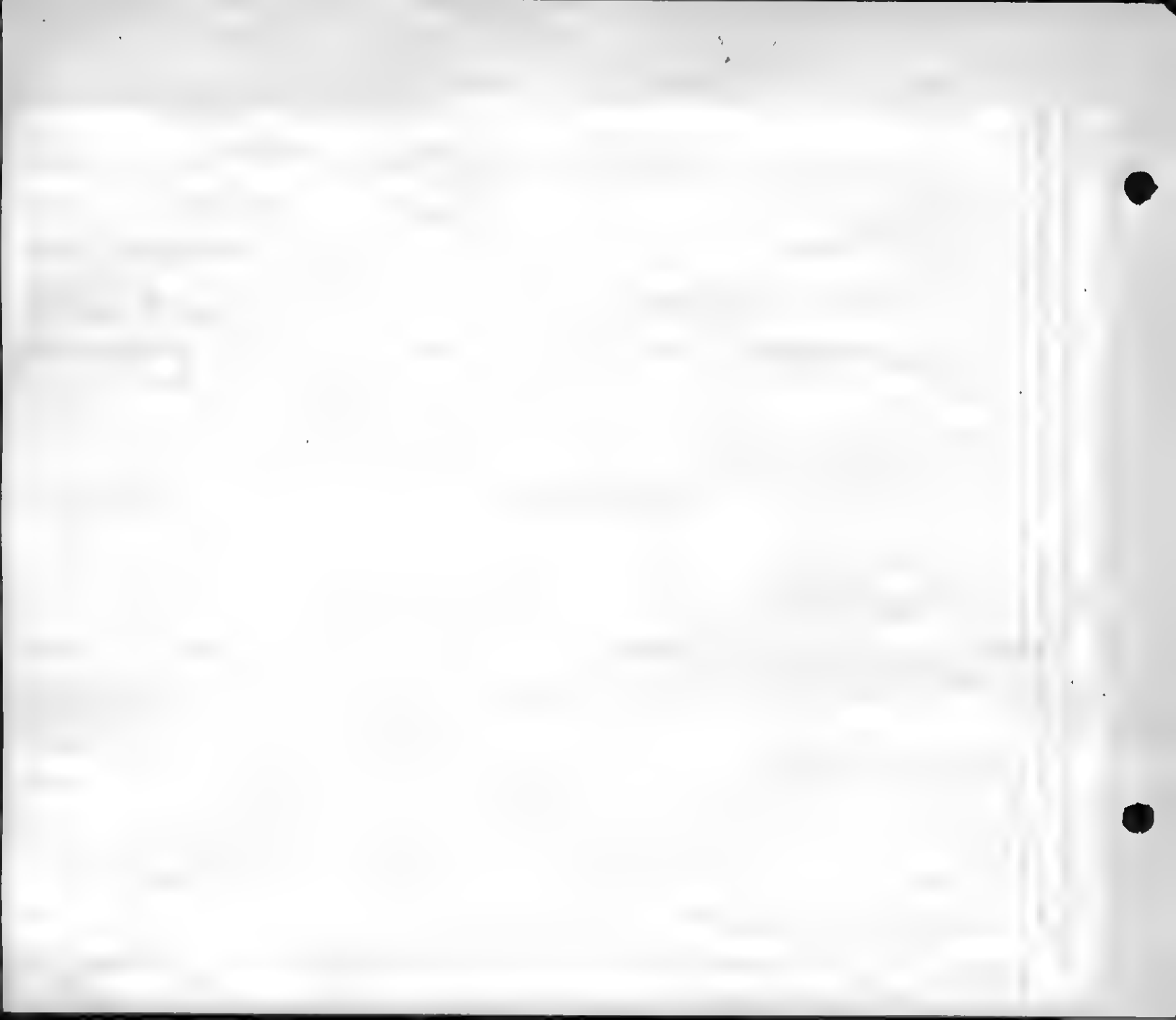
10472

10478

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) <i>Ruth Blizzard</i>		2. DATE OF DEATH <i>Nov 26 1955</i>	
3. PLACE OF DEATH A. Baltimore City, Maryland <i>Baltimore</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: resident) A. STATE <i>Maryland</i> B. COUNTY <i>Carroll</i>	
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>Armacost Nursing Home</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <i>Baltimore</i>	
6. Length of stay in Baltimore <i>10</i> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>525 Register Avenue</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>1892</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Nurse-seamstress</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Rosewood Training</i>	9. AGE (In years last birthday) <i>63</i>
11. BIRTHPLACE (State or foreign country) <i>Carroll Co.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>John W. Blizzard</i>		14. MOTHER'S MAIDEN NAME <i>Minnie Erb</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Roberta Remley-525 Register Ave</i>		ADDRESS	
18. <i>172X</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			
CAUSE OF DEATH (A) <i>Generalized Osteomyelitis</i> DUE TO (B) <i>Pharyngeal carcinoma of Fauces of Uvula</i> DUE TO (C) <i>Secondary carcinoma of the lungs</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. SIGNATURE OF INJURY		21. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <i>January</i> , 1954, to <i>Nov. 26</i> , 1955, that I last saw the deceased alive on <i>Nov. 26</i> , 1955, and that death occurred at <i>F.A.M.</i> , from the causes and on the date stated above.		23. ADDRESS <i>Cambridge Arms Co. Annapolis</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11-29-55</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Kriders Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Carroll Co.</i>	
DATE RECEIVED BY LOCAL REGISTRAR		25. FUNERAL DIRECTOR <i>Wiedeck & Son</i>	
REGISTRAR'S SIGNATURE		ADDRESS	



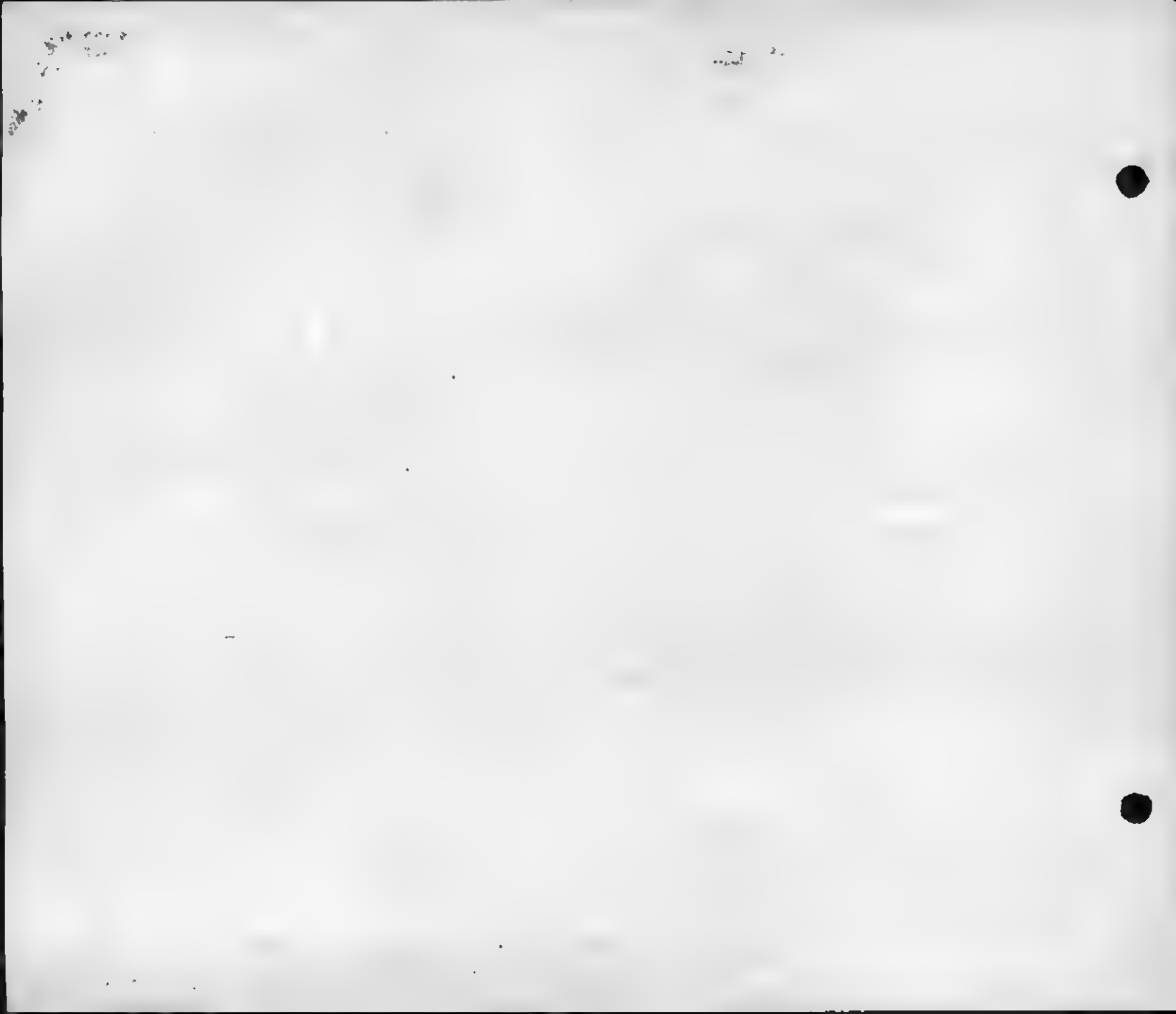
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10473
10479 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Pikesville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pikesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2 Pikesville Rd.</u>		STREET ADDRESS (If rural give location) <u>2 Pikesville Rd.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ALBERT</u> <u>BOONE</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Nov.</u> <u>23</u> , 19 <u>55</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH: <u>Dec. 6, 1880</u>
9. AGE last birthday <u>74</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Carpenter (rtd)</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>--</u>	
11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>J. H. R. Boone</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth --</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Mrs. M. Freeman-1619 W. North Ave.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>		<u>10 days</u>	
ANTECEDENT CAUSE (B) <u>Hypertension</u>		<u>5 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Hypertension</u>		<u>5 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Myocardial infarction</u>		<u>2 yrs</u>	
19A. DATE OF OPERATION: <u>✓</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>✓</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-23-55</u> to <u>11-23-55</u> , that I last saw the deceased alive on <u>11-23-55</u> , and that death occurred at <u>8:45 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>11-25-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/26/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Chester Cem.</u>		LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11-25-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>[Address]</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

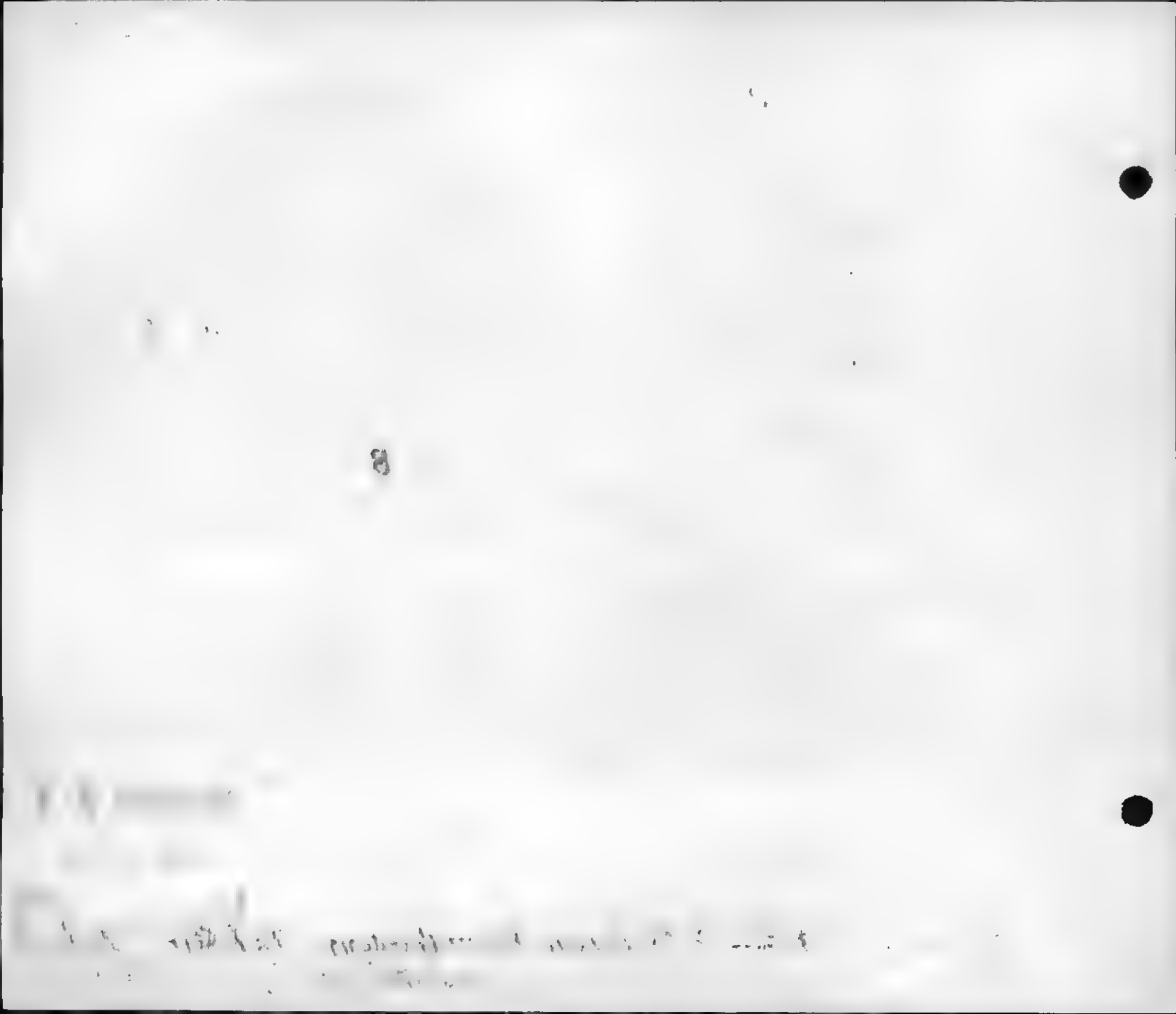
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, '18

10474

10430
CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL, and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cockeysville</u>			
X TOWN <u>Cockeysville</u>		<u>11 yrs</u>		STREET ADDRESS (If rural give location) <u>Cedar Knoll Road</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>Nov. 29 1955</u>			
<u>Irene Lillian Breidenbaugh</u>							
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH: <u>August 21, 1918</u>	9. AGE last birthday <u>37</u> yrs	IF UNDER 1 YEAR: Months <u>3</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>00</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Wilmington, DE.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Walter R. Heaps</u>				14. MOTHER'S MAIDEN NAME: <u>Emma Horn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS: <u>Harvey B. Breidenbaugh, Cockeysville Md.</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>973.3</u>							
IMMEDIATE CAUSE				(A) <u>Carbon monoxide poisoning</u>			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <u>accident</u>			
				DUE TO			
				(C) <u>100% - 100% - 100%</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>1951</u> , to <u>Nov 27, 1955</u> that I last saw the deceased alive on <u>Nov 25, 1955</u> , and that death occurred at <u>11:25 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS		DATE SIGNED <u>11/27/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>DEC-2, 55</u>		NAME OF CEMETERY OR CREMATORY <u>Bellair Mount Gardens</u>		LOCATION (City, town, or county) (State) <u>Bell Air Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>[Address]</u>	



10481

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	OR TOWN
TOWN <u>Towson</u>		TOWN <u>Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>66 Burkleigh Square</u>		STREET ADDRESS (If rural give location) <u>66 Burkleigh Square</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Joseph McSorley Bright</u>		OF DEATH <u>Nov. 3, 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>May 7, 1907</u>
9. AGE last birthday <u>48</u> yrs.		10. AGE last birthday IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bank Teller Md. Trust Co.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Md. Trust Co.</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>James B. Bright</u>		14. MOTHER'S MAIDEN NAME: <u>Matilda Cook</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY No. <u>217-14-5472</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Gertrude Bright, Towson, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>		<u>2 Hrs.</u>	
ANTECEDENT CAUSE (B) <u>Hypertensive Cardio-</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Renal Vascular Disease</u>		<u>8 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) (Min.)		21F. HOW DID INJURY OCCUR?	
21G. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>June 1949</u> to <u>Nov 3, 1955</u> , that I last saw the deceased alive on <u>Nov 3, 1955</u> , and that death occurred at <u>5:15</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Charles F. Donnell</u>		ADDRESS <u>7501 York Rd. Towson, Md.</u>	
DATE SIGNED <u>11/4/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Nov. 5, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Norland Memorial</u>		LOCATION (City, town, or county) (State) <u>Parkville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Nov. 5, 1955</u>		REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>	
FUNERAL DIRECTOR <u>John Burner</u>		ADDRESS <u>Somerset, Towson, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100-100000

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11

100-100000

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10482

CERTIFICATE OF DEATH

10476

Reg. Dist. No. 45

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE (24)</u>		LENGTH OF STAY (In this place) <u>2 MONTHS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE (24)</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7032 BANK ST.</u>				STREET ADDRESS (If rural give location) <u>7032 BANK ST.</u>		1	
3. NAME OF DECEASED (Type or Print) <u>GEORGE CARROLL BRUCE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>11-5-55</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>10 NOV. 1899</u>	9. AGE last birthday <u>55</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PERSONNEL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL & SHIP MFG.</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALBERT BRUCE</u>				14. MOTHER'S MAIDEN NAME <u>MARIE ANDERSON BRUNE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-09-1948</u>		17. INFORMANT & ADDRESS <u>AGNES S. BRUCE - SAME</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
180X IMMEDIATE CAUSE (A) <u>Carcinoma of Rectum, 3 Metastases</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>			
ANTECEDENT CAUSE(S) DUE TO <u>INVASIVE GUT CAUSE - MET. FIST. - 1 yr.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>Oct. 15 - 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>Same</u>		20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Home</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Home</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>11-5-55</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Slipped</u>			
22. I hereby certify that I attended the deceased from <u>Oct. 15</u> , 19 <u>55</u> , to <u>Nov. 5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov. 4</u> , 19 <u>55</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edith Hurley</u>				DATE SIGNED <u>11-8-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>11-8-55</u>		NAME OF CEMETERY OR CREMATORY <u>OLAK LAWN</u>		LOCATION (City, town, or county) (State) <u>BALTO. Co. MD.</u>	
24. REC'D BY REGISTRAR <u>11/8/55</u>		REGISTRAR'S SIGNATURE <u>Edith Hurley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edith Hurley</u>		ADDRESS <u>Edith Hurley, 11-8-55</u>	



10483

10477

CERTIFICATE OF DEATH

Reg. Dist. No.

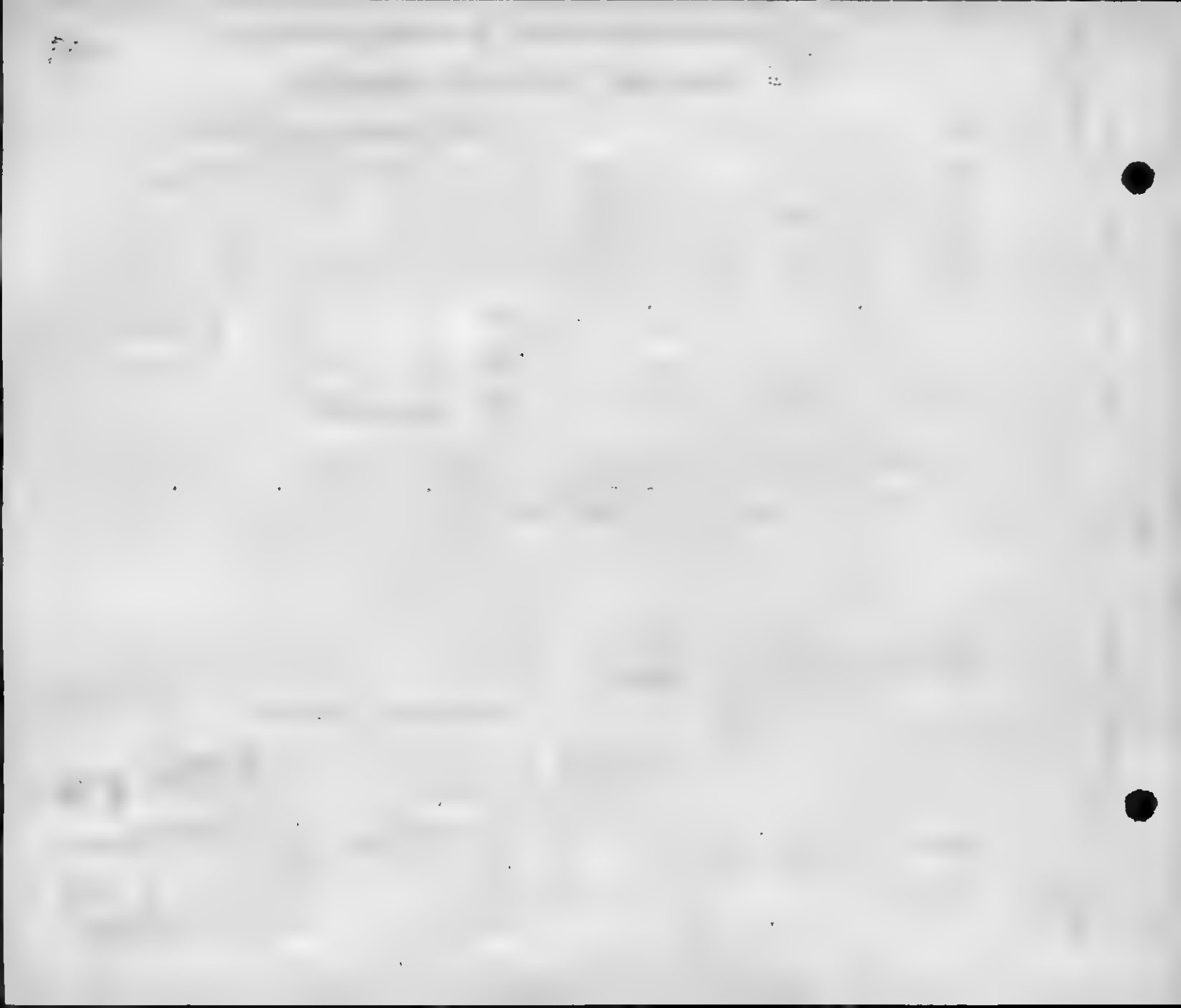
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Parkville</u>				TOWN <u>Parkville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7414 Park Drive</u>				STREET ADDRESS (If rural give location) <u>7414 Park Drive #14</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Mr. Walter L. Carroll</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>November 26th, 1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Nov. 27, 1880</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Buyer, Sporting Goods</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Mr. Michael Carroll</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-03-7553</u>		17. INFORMANT & ADDRESS <u>Mrs. Katherine H. Carroll. Park Drive 7414</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I / DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary artery disease</u>						<u>2 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/30</u> , 19 <u>52</u> , to <u>11/26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/26</u> , 19 <u>55</u> , and that death occurred at <u>9 A.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M.D. <u>7122 Harford Rd, Balt 14</u>		DATE SIGNED <u>11/26/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov 29 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>Nov 28, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck, 5305 Harford Road #14</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10484

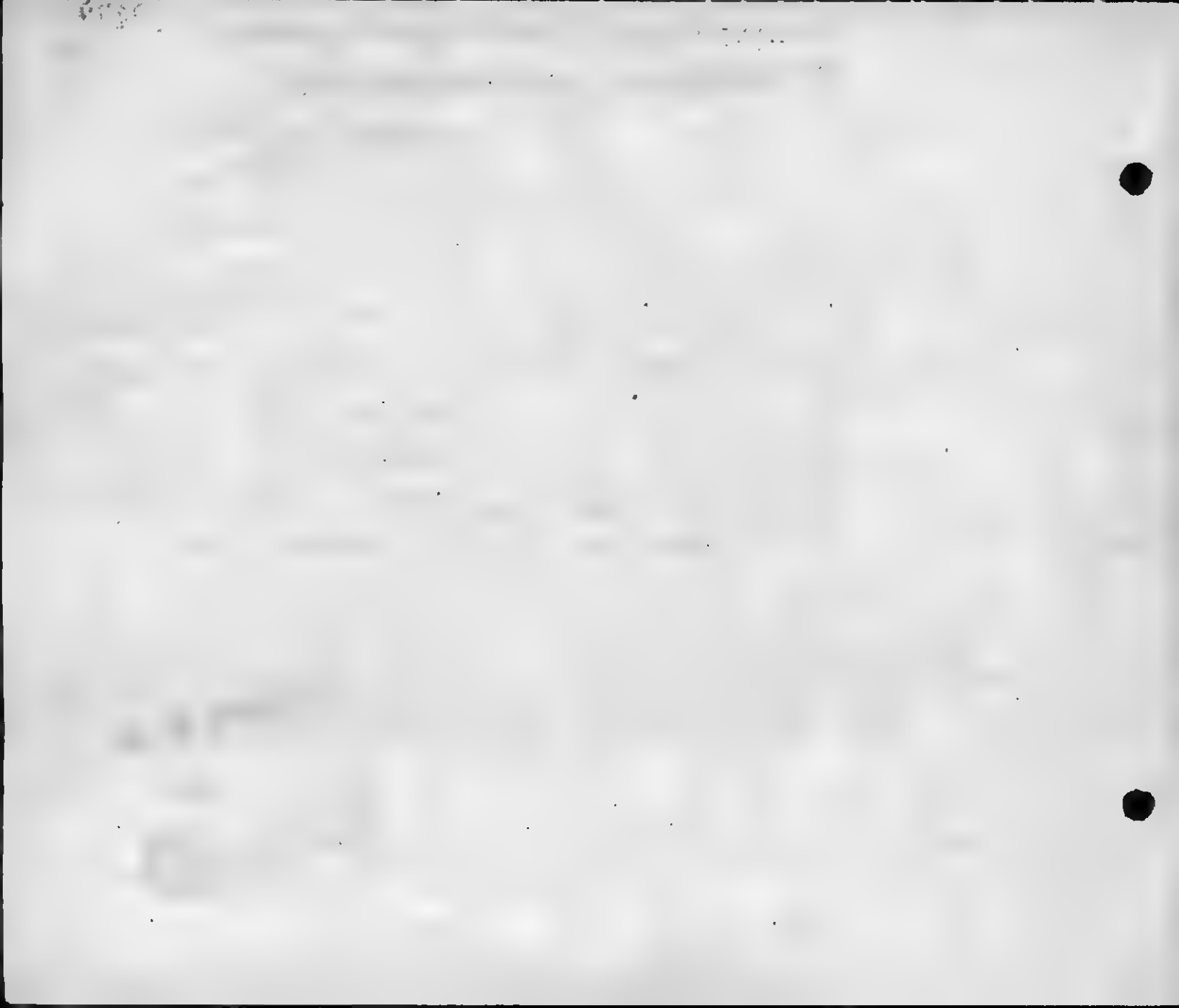
CERTIFICATE OF DEATH

10478

38

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Carney</u>				TOWN <u>Carney</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS		(If rural give location)	
00 <u>8728 Satyr Hill Road</u>				<u>8728 Satyr Hill Road</u>		1	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Mrs.</u> (Middle) <u>Marie</u> (Last) <u>K. Cesky</u>				(Month) <u>November</u> (Day) <u>7th</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>female</u>	<u>white</u>	<u>widowed</u>	<u>May 30, 1871</u>	<u>84</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>at home</u>				<u>Baltimore, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Mr. Albert Wohrna</u>				<u>Louise Von Neuburg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)				<u>Mr. Charles Cesky, 8728 Satyr Hill Road</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE (A) <u>ARTERIOSCLEROTIC HEART DIS.</u>						<u>5 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>GENERALIZED ARTERIOSCLEROSIS</u>						<u>10 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 5, 1954</u> , to <u>Nov 7, 1955</u> , that I last saw the deceased alive on <u>Nov 4, 1955</u> , and that death occurred at <u>445 P.</u> from the causes and on the date stated above.							
SIGNATURE <u>George H. Hays</u>		M.D. <u>4808 Harford Rd. Baltimore 14</u>		DATE SIGNED <u>11/8/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Nov. 10, 1955</u>		<u>Lorraine Park</u>		<u>Baltimore, Md.</u>	
24. RECEIVED BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Nov. 9, 1955</u>		<u>Mabel Gray</u>		<u>Leonard J. Ruck, 5305 Harford Road #14</u>			



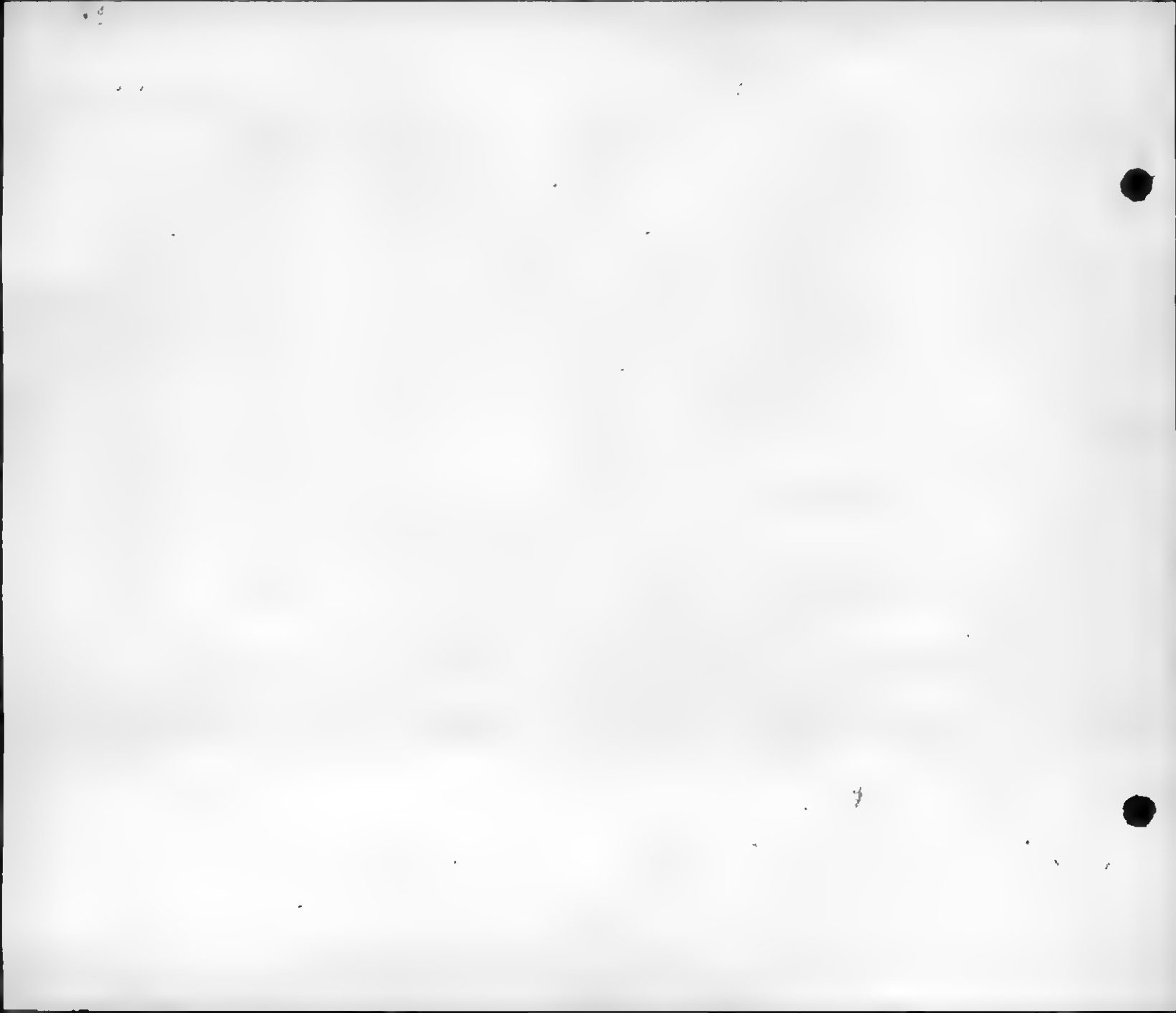
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10479
10485 CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Owings Mills</u>		LENGTH OF STAY (In this place) <u>2 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>		<u>2 yrs. 4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rosewood State Tr. School</u>				STREET ADDRESS (If rural give location) <u>2121 Huntingdon Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Eugenia Mae Chambers</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>11</u> <u>30</u> <u>19 55</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>11/25/49</u>	9. AGE last birthday: <u>6</u> yrs		10. UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Child</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Eugene Luther Chambers</u>				14. MOTHER'S MAIDEN NAME: <u>Dorothy Mae Whitney</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Rosewood Records</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						1 day	
IMMEDIATE CAUSE (A) <u>Bilateral Aspiration Pneumonia</u>							
ANTECEDENT CAUSE (B) <u>Congenital Spastic Paraplegic with</u>						since birth	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Cranial Anomaly</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>C</u>		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/29</u> , 19 <u>55</u> , to <u>11/30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/30</u> , 19 <u>55</u> , and that death occurred at <u>9:05pm</u> , from the causes and on the date stated above.							
SIGNATURE <u>Harry B. Butler</u>		M. D. <u>Owings Mills</u>		DATE SIGNED <u>12/1/55</u>			
23. BURIAL, CREMATION, REMOVAL, (Specify)		DATE THEREOF <u>12/3/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>		LOCATION (City, town, or county) (State) <u>7930 Frederick Ave. St.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Dec 4, 1955</u>		REGISTRAR'S SIGNATURE <u>A. L. H. H. H.</u>		24. FUNERAL DIRECTOR <u>John J. Gowan</u>		ADDRESS <u>St. Hollins</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



10480

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10486 CERTIFICATE OF DEATH

Reg. Dist. No.

2. DATE OF DEATH 11/24/55

1. NAME OF DECEASED (Type or Print) Sonja Ann Chapin

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore Md

B. FULL NAME OF (If not in hospital or institution, give street address or location) 1625 HARDWICK RD #4

C. Length of stay in Baltimore Many years Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md

D. STREET ADDRESS (If rural, give location) 1625 Hardwick Road #4

5. SEX Female 6. COLOR OR RACE White 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH Jan 31-22 9. AGE (In years last birthday) 33

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Samarra, Dutch Ind. 12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME Derk Kersten

14. MOTHER'S MAIDEN NAME Gysela Spruiellman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO 17. INFORMANT Husband ADDRESS same

18. 193X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Brain Tumor Primary (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) Carcinoma DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II 19A. DATE OF OPERATION June 7-1955 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Brain Tumor 20. AUTOPSY? YES NO X 21. HOW DID INJURY OCCUR? WHILE AT WORK NOT WHILE AT WORK

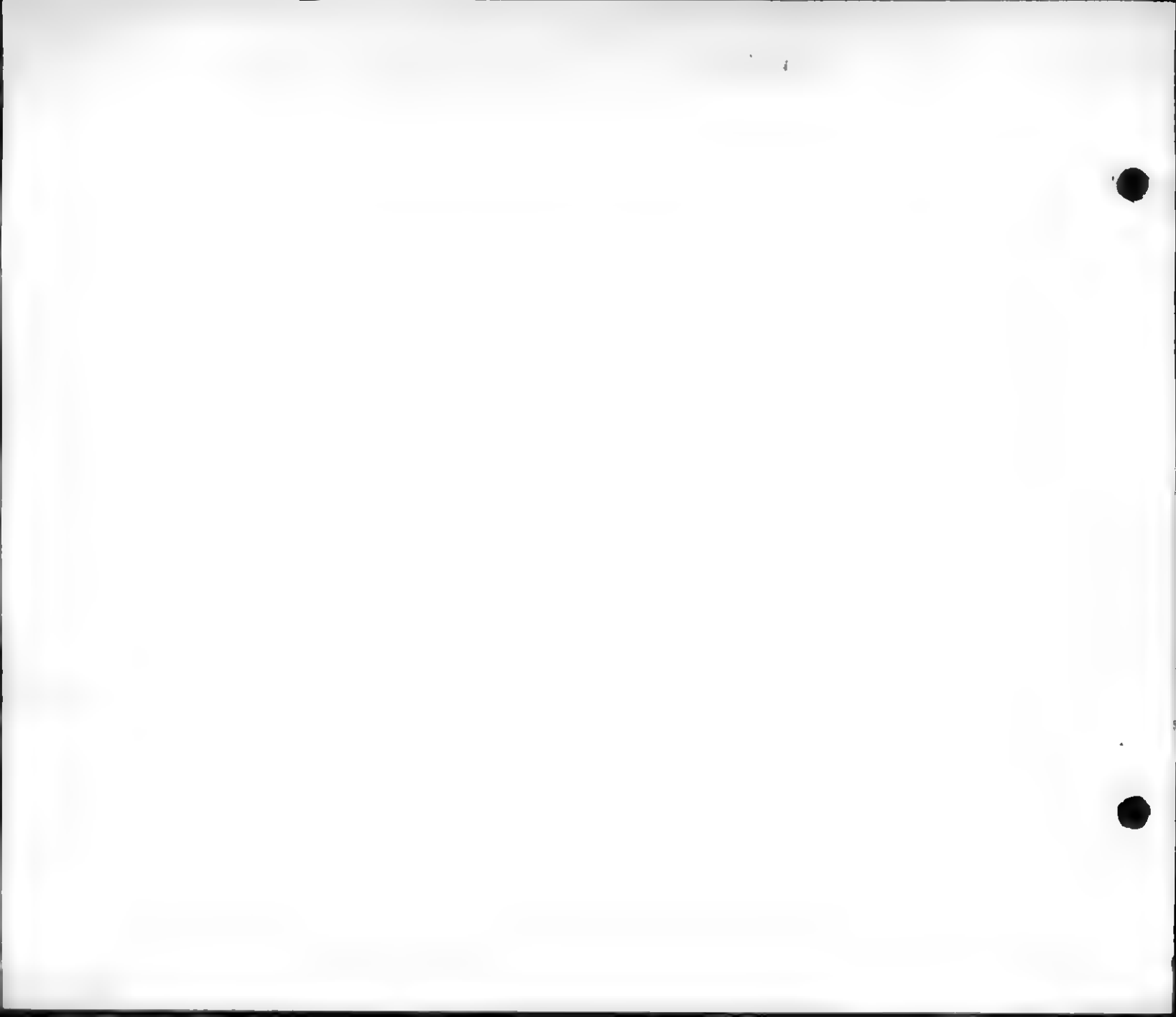
22. I certify that (I) (this hospital) attended the deceased from approx. one year to 1955, that (I) (we) last saw the deceased alive on Nov 23 1955, and that death occurred at ... m., from the causes and on the date stated above.

23A. SIGNATURE [Signature] 23B. ADDRESS 715 Med Arts Bldg 23C. DATE SIGNED 11/25/55

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial 24B. DATE 11/28/1955 24C. NAME OF CEMETERY OR CREMATORY Mt. Cedarnur 24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE [Signature] 25. FUNERAL DIRECTOR [Signature] ADDRESS 5305 Harbor

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information be carefully supplied. Physicians: please write the causes of death clearly and let HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-53 10M

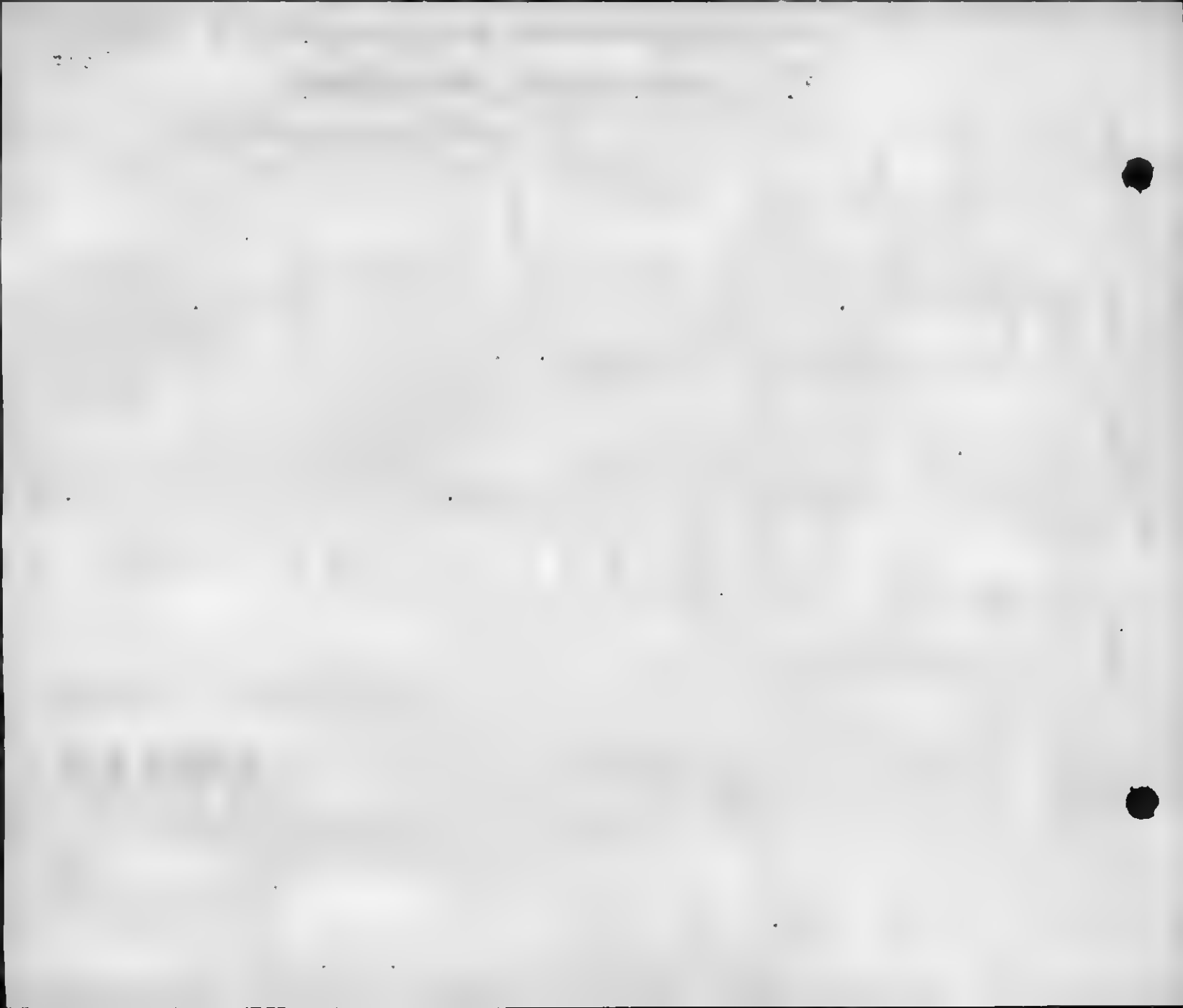
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10481

10487 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Catonsville	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Catonsville				TOWN Baltimore		3111	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 16 Fusting Avenue (House in Pines)				STREET ADDRESS (If rural give location) 3119 Royston Avenue #14			
3. NAME OF DECEASED (Type or Print) Mrs. Tinie Florence Chason				4. DATE OF DEATH Nov. 22nd 19 55			
5. SEX female		6. COLOR OR RACE white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed		8. DATE OF BIRTH Dec. 14, 1887	
				9. AGE last birthday 67 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Strasburg, Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Mr. James Turner Rau				14. MOTHER'S MAIDEN NAME Maggie Carroll Richardson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. James Chason 4109 Montana Ave. #6	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
491X IMMEDIATE CAUSE (A) Broncho Pneumonia						17mo	
ANTECEDENT CAUSE(S) DUE TO (B) Parkinson's Disease						10 years?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8-11-1950, to 11-22-1955, that I last saw the deceased alive on 11-22-1955, and that death occurred at 11 P.M. from the causes and on the date stated above.							
SIGNATURE William K. Gallagher				ADDRESS (Street, city, town, state) M.D. 6207 Frederick Ave. Baltimore 282nd 11/23/53		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Nov. 25, 1955		NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		LOCATION (City, town, or county) Baltimore, Maryland	
24. REC'D BY REGISTRAR T. E. Harvey		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, 5305 Harford Road #14		ADDRESS	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

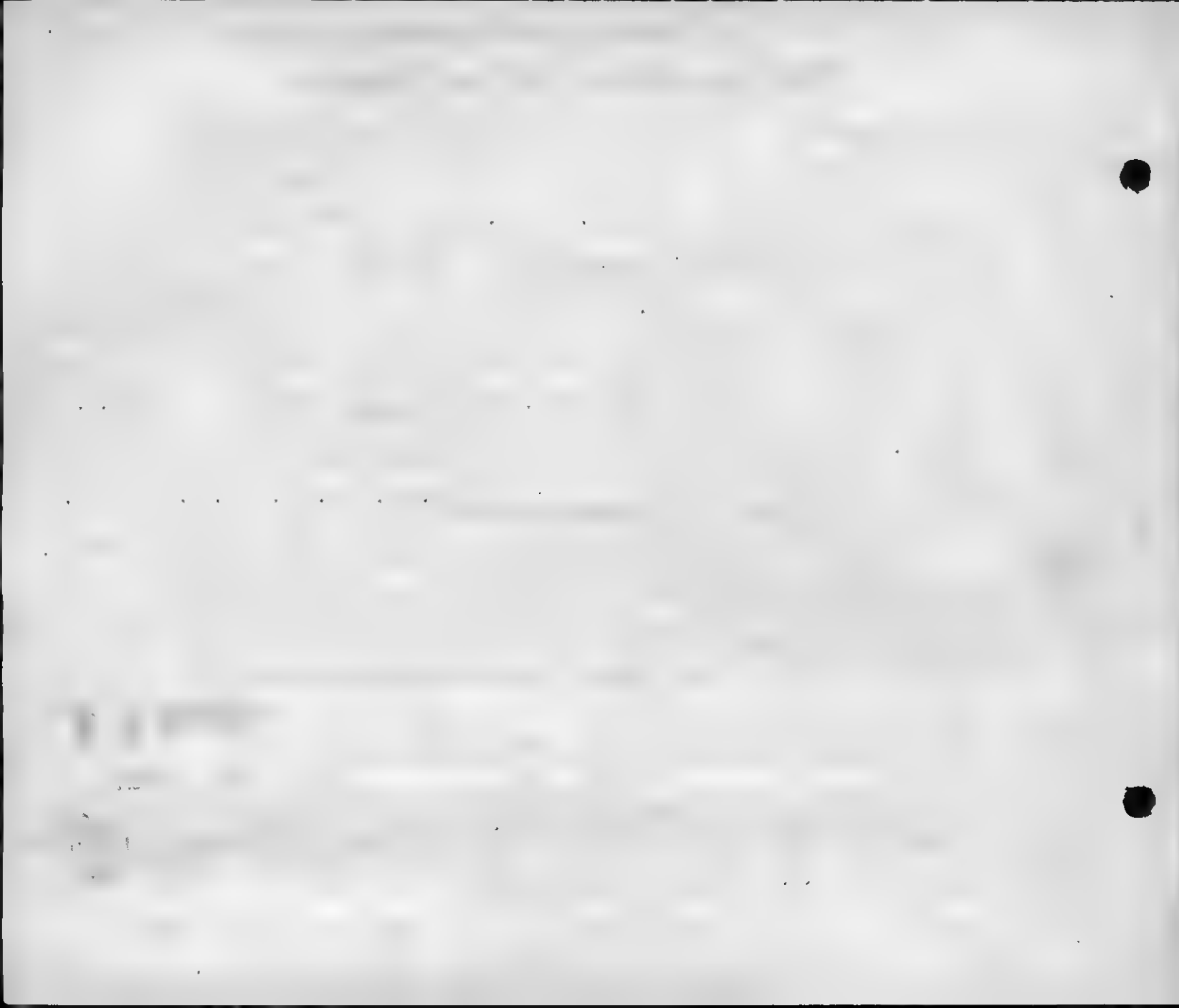
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10488 CERTIFICATE OF DEATH

10482

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY BALTIMORE		STATE MARYLAND		STATE MARYLAND		COUNTY BALTIMORE	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN FORT HOWARD		23 hrs. 40 mins.		TOWN REISTERSTOWN		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital				STREET ADDRESS (If rural give location) CHERRY HILL ROAD			
3. NAME OF DECEASED (Type or Print) HAROLD P. COFIELD				4. DATE OF DEATH (Month) NOVEMBER (Day) 12 (Year) 19 55			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH 11/19/23	9. AGE last birthday 31 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LINEMAN			10b. KIND OF BUSINESS OR INDUSTRY GAS & ELECTRIC CO.		11. BIRTHPLACE (State or foreign country) SYKESVILLE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ELMER C. COFIELD				14. MOTHER'S MAIDEN NAME MAMIE PHILLIPS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) YES WWII		16. SOCIAL SECURITY NO. 219-14-8263		17. INFORMANT & ADDRESS CLIN. REC., VET. ADM. HOSP. FT. HOWARD, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) 42-1 CORONARY OCCLUSION						INTERVAL BETWEEN ONSET AND DEATH 36 HRS.	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. OBESITY							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White at work Not white at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that VA attended the deceased from September 19 55 to September 12 55 , and that death occurred at 5:00 P.M. from the causes and on the date stated above.							
SIGNATURE John S. Surmont				ADDRESS (Street, city, town, state) M.D. VAH FORT HOWARD, MARYLAND			
DATE SIGNED 11/12/55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 11-15-55		NAME OF CEMETERY OR CREMATORY OAKLAND		LOCATION (City, town, or county) (State) OAKLAND, MARYLAND	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Dawson L. Lark		25. FUNERAL DIRECTOR'S SIGNATURE WEEER-HAIGHT FUNERAL DIRECTOR			
DATE Nov 17 1955				ADDRESS MAIN STREET, SYKESVILLE, MARYLAND			



10452 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) Dundalk LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md COUNTY 1CITY (If outside corporate limits, write RURAL and give nearest town) Dundalk

STREET ADDRESS (If rural give location)

424 Trappe Road

3 NAME OF DECEASED:

(First) Bessie

(Middle)

(Last) Coleman

4. DATE OF DEATH:

(Month)

(Day)

(Year)

Nov 13/55

19

5. SEX:

female

6. COLOR OR RACE:

white7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH:

July 21, 1877

9. AGE last birthday:

78 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): At home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Penna.12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

Harry Diesroth

14. MOTHER'S MAIDEN NAME:

Alice Arnold

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No.

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Mrs. Frances Kolstrom 424 Trappe Road. 22

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

163X
Immediate cause(a) ... Carcinoma of lungs
DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) ...
DUE TO

(c)

Interval Between Onset And Death

2 yrs.

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept, 19 55, to Oct, 19 55, that I last saw the deceasedalive on Nov 13, 19 55, and that death occurred at 8:45 PM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

69

Broadship

Dundalk

DATE SIGNED

Nov 13 '55

23. BURIAL, CREMATION, REMOVAL (Specify)

Burial

DATE THEREOF

Nov. 17, 1955

NAME OF CEMETERY OR CREMATORY

Oak Lawn

LOCATION (City, town, or county)

Colgate, Md.

(State)

DATE REC'D BY LOCAL REGISTRAR

11/15/55

REGISTRAR'S SIGNATURE

A. W. Hedrick

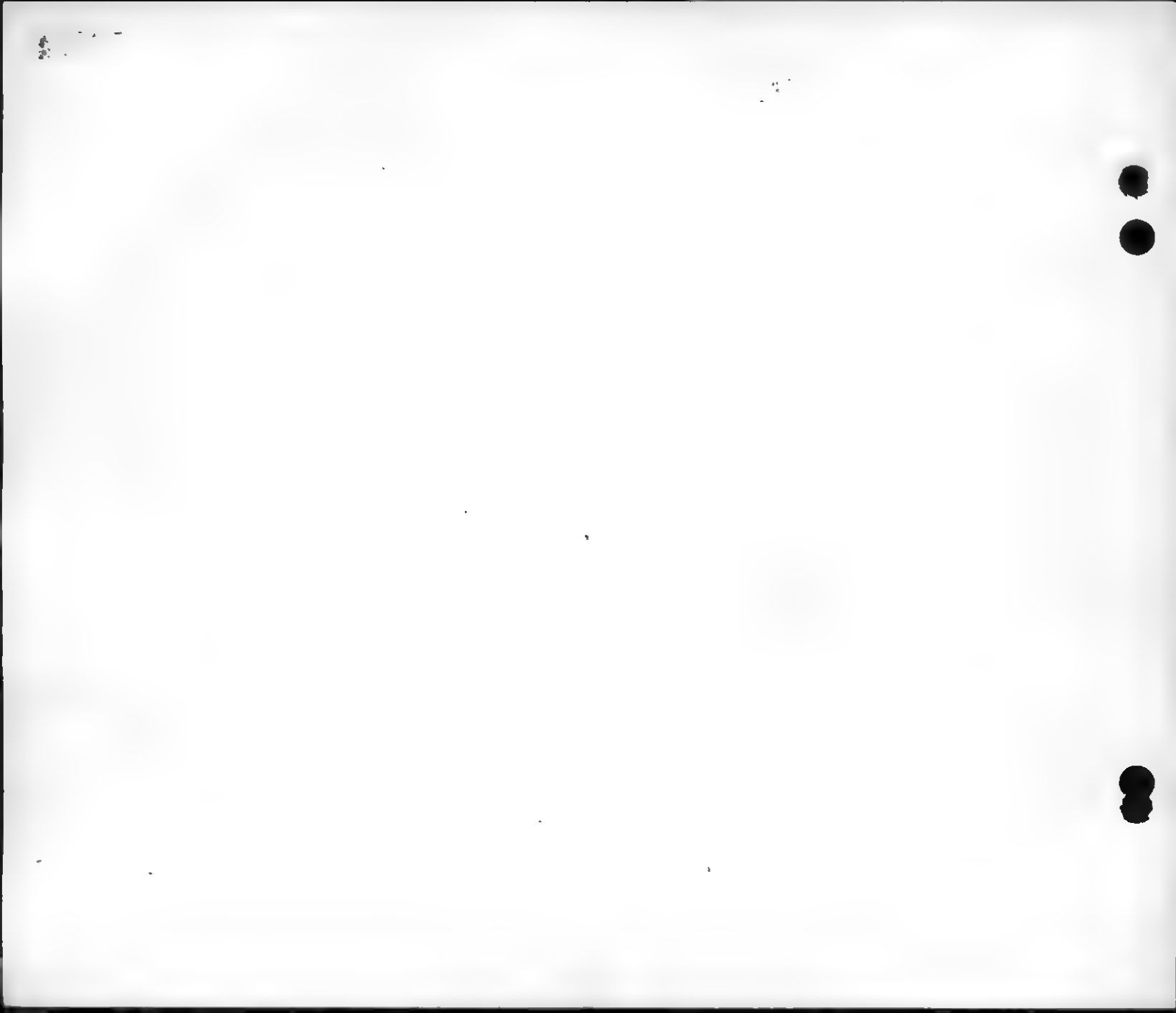
24. FUNERAL DIRECTOR

Ullrich Funeral Home 2112 Dundalk Ave

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
10489 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

10485

Reg. Dist. No. 33

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural-Parkton</u> LENGTH OF STAY (In this place) <u>74 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural-Parkton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rayville</u>		STREET ADDRESS (If rural, give location) <u>Rayville</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Charles</u> (Middle) <u>A.</u> (Last) <u>Cooper</u>		4. DATE OF DEATH (Month) <u>Nov.</u> (Day) <u>21</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Dec. 13, 1880</u>
9. AGE last birthday <u>74</u> yrs.		10. AGE last birthday If under 1 year Months Days	11. AGE last birthday If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Parkton, Md. R.D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James W. Cooper</u>		14. MOTHER'S MAIDEN NAME <u>Clara Armacost</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>---</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Sydney Colter - Parkton, Md. R.D.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) <u>443X</u> Immediate cause <u>Cardio-vascular-renal disease</u>			
(b) Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last <u>---</u>			
(c) <u>---</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		PLACE (Home, farm, factory, street, or office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>A. M. France</u> M.D. <u>Parkton, Md.</u>		DATE SIGNED <u>11/23/55</u>	
23. BURIAL, CREMATION OR MOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Nov. 23, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Pine Grove Cemetery</u>		LOCATION (City, town, or county) (State) <u>Parkton, Balto. Co., Md.</u>	
24. FUNERAL DIRECTOR <u>Phyllis J. Sullivan</u>		ADDRESS <u>1400 N. Washington, Wash. D.C.</u>	



1000
1000



10490 CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort Howard LENGTH OF STAY (in this place) 45 Days

HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3401-4

STREET ADDRESS (If rural give location)
2132 Harman Avenue

3. NAME OF DECEASED:

(First) (Middle) (Last)
RANDOLPH T. COOPER

4. DATE (Month) (Day) (Year)
 OF DEATH: November 26 1955

5. SEX:

Male

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH:

August 23, 1909

9. AGE last birthday:

46 yrs.

10. IF UNDER 1 YEAR 11. IF UNDER 24 HRS.
 Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Policeman

10B. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Reisterstown, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME:

Harry T. Cooper

14. MOTHER'S MAIDEN NAME:

Gertrude Townsend

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) Yes WW II

16. SOCIAL SECURITY NO. 218-03-8193

17. INFORMANT & ADDRESS:

Clin. Rec. Vet. Adm. Hosp. Ft. Howard, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

163x

IMMEDIATE CAUSE

(A) SQUAMOUS CELL CARCINOMA, LEFT LUNG

ANTECEDENT CAUSE (B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

1 YEAR

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 12, 1955 to Nov. 26, 1955 and that death occurred at 5:55 A.M. from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

William H. Slasman, M.D.

M.D. VAH, FORT HOWARD, MARYLAND

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial

Nov 29-1955

Baltimore National Cem. Baltimore, Maryland

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Edward Toulson Funeral Home, 2359 Washington Blvd.

MARGIN RESERVED FOR BINDING

11

2
100

100
100

10491 CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>X</u> TOWN <u>Rural Pikesville</u>	LENGTH OF STAY (in this place) <u>Lifetime</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Pikesville</u> <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <u>100 Sherwood Ave., Pikesville</u>	

3. NAME OF DECEASED: (First) (Middle) (Last) <u>John Winand Corbett</u>			4. DATE (Month) (Day) (Year) OF DEATH: <u>Nov. 28</u> 19 <u>55</u>		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>October 30, 1892</u>	9. AGE last birthday: <u>63</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Baltio. County</u>			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>Robert Corbett</u>			14. MOTHER'S MAIDEN NAME: <u>Kathrine Winand</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes W.W.I</u>			16. SOCIAL SECURITY NO		
			17. INFORMANT & ADDRESS: <u>John W. Corbett Jr., Pikesville</u>		

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Acute coronary occlusion</u>		<u>one minute</u>
ANTECEDENT CAUSE (B) <u>Arterio-sclerosis</u>		<u>10 yrs.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>chr. bronchitis & emphysema</u>		<u>5 yrs.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>11</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
--	--	--

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from Feb, 1955, to Nov 28, 1955, that I last saw the deceased alive on Nov 26, 1955 and that death occurred at 10 AM, from the causes and on the date stated above.

SIGNATURE <u>Colman F. Williams</u>	ADDRESS <u>Pikesville, Md.</u>	DATE SIGNED <u>Nov 29, 55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>Dec. 1, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>
		LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>

DATE REC'D BY LOCAL REGISTRAR <u>Nov. 29, 1955</u>	REGISTRAR'S SIGNATURE <u>Dorothy G. Newell</u>	24. FUNERAL DIRECTOR <u>Frank H. Newell</u>	ADDRESS <u>Pikesville</u>
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MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 7 19

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

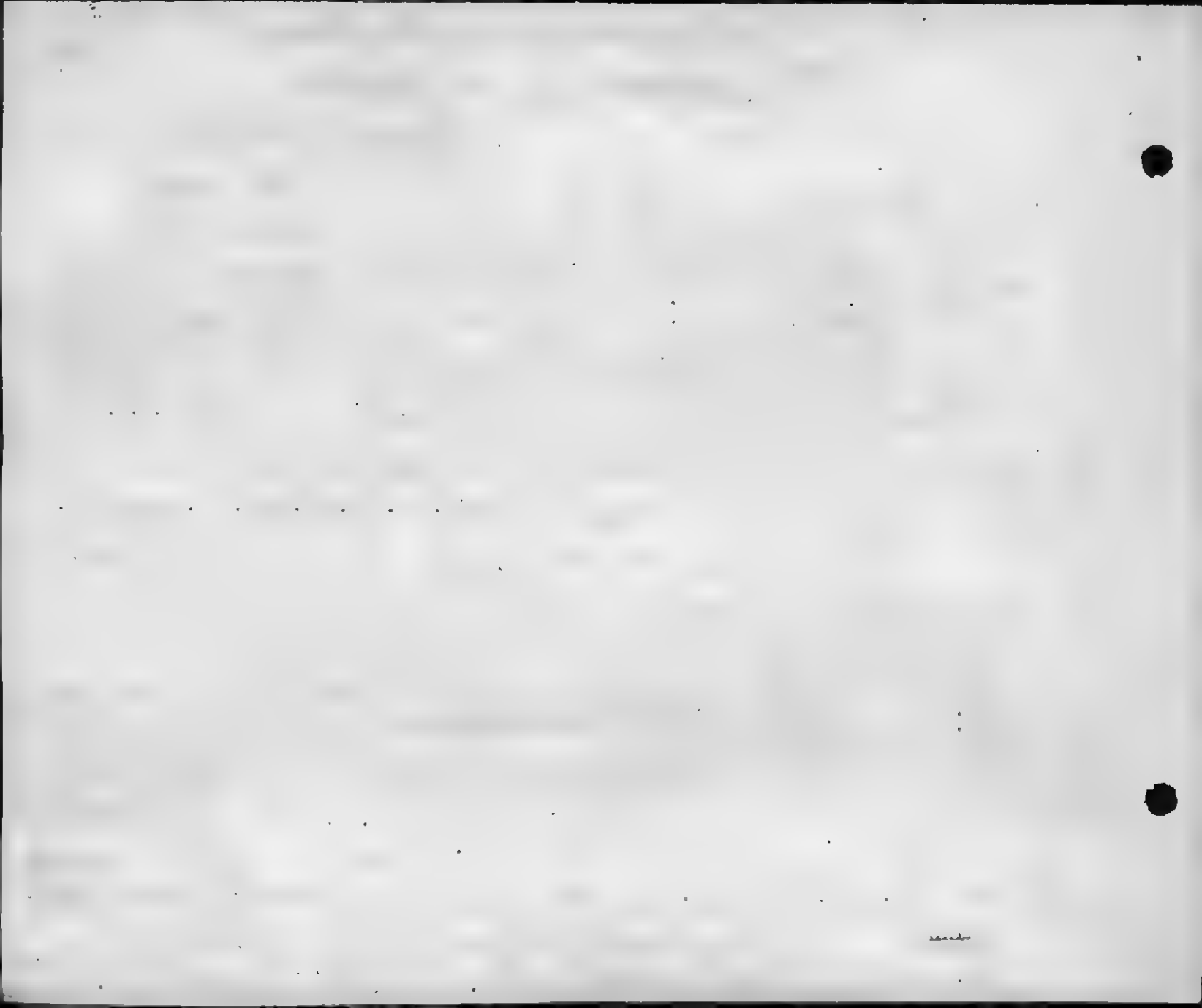
10492

CERTIFICATE OF DEATH

10487

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>1</u>			
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort Howard</u>		<u>102 Days</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>15 Propeller Drive</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Also: Marcella</u> (Middle) <u>G.</u> (Last) <u>Downes</u>				(Month) <u>November</u> (Day) <u>4</u> (Year) <u>1955</u>			
MARCELLA G. CRANDALL							
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)		
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>11/19/07</u>	<u>47</u> yrs.			
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Housewife</u>					<u>Crestline, Ohio</u>		<u>U.S.A.</u>
13. FATHER'S NAME <u>Arthur Downes</u>				14. MOTHER'S MAIDEN NAME <u>Mable Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>Yes</u> <u>WW-II</u>				<u>219-30-7409</u>		<u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>	
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
170X IMMEDIATE CAUSE (A) <u>CARCINOMA OF BREAST, LEFT</u>						<u>2 years</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>Aug. 1954</u>		19b. MAJOR FINDINGS OF OPERATION <u>Left mastectomy for carcinoma</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>Dec. 1954</u>		<u>Left Craniotomy for metastases</u>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
		M. <input type="checkbox"/> <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>July 25</u> , 19 <u>55</u> , to <u>Nov. 4</u> , 19 <u>55</u> , that I last saw the deceased <u>alive</u> and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William B. Vandegriest</u>				DATE SIGNED <u>11/5/55</u>			
M.D. <u>VAH, Fort Howard, Maryland</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>Nov 10, 1955</u>		<u>Arlington National</u>		<u>Fort Myer, Virginia</u>	
24. REG'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Nov. 7, 1955</u>		<u>Lawson L. Farley</u>		<u>Amber Blight Inc.</u>		<u>6009 Harford Rd</u>	
				<u>Wm. Cook-Blight Funeral Home Balto., Md.</u>			



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10493 CERTIFICATE OF DEATH

10488

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Baltimore</u>				TOWN <u>Baltimore</u>		3 Nov. 4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5743 Edmondson Avenue</u>				STREET ADDRESS (If rural give location) <u>2409 Barclay Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Miss Clara Crevensten</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 13th 19 55</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>		8. DATE OF BIRTH <u>June 27, 1872</u>	
				9. AGE last birthday <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
						Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dress Maker</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Aberdeen, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Mr. George Crevensten</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Welch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Frank Harten, 2713 Woodsdale Ave.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Cerebrovascular Accident</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Renal infarction</u>				-			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 15, 1953</u> to <u>Nov. 13, 1955</u> , that I last saw the deceased alive on <u>Nov. 10, 1955</u> , and that death occurred at <u>10:10 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>J. Nelson McKee</u>				M.D. <u>6014 Edmondson Ave</u>		DATE SIGNED <u>11/15/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 16, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Grove Presby Cemetery</u>		LOCATION (City, town, or county) <u>Aberdeen, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Victor E. Harvey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck, 5305 Harford Road #14</u>			
DATE							

11/10/19

10489

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10494 CERTIFICATE OF DEATH

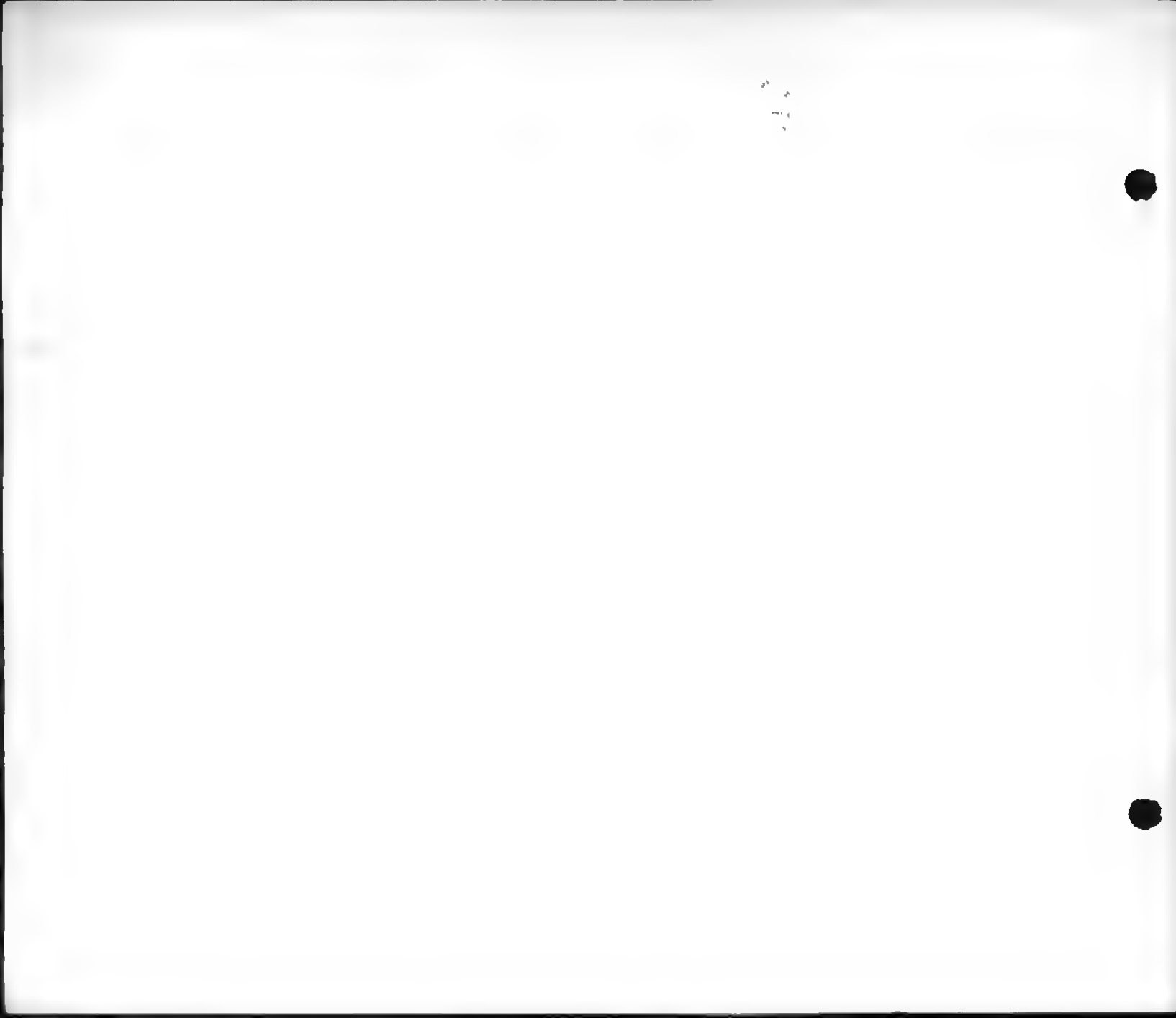
Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) Ruby Garland Crosby			2. DATE OF DEATH Nov. 29, 1955		
3. PLACE OF DEATH: A. Baltimore City , Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
B. FULL NAME OF (If not in hospital or institution, give street address or location) 7711 Old Harford Road			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
C. Length of stay in Baltimore 00 Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 7711 Old Harford Road #14		
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Oct. 5, 1888	9. AGE (In years last birthday) 67	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home			11. BIRTHPLACE (State or foreign country) Crisfield, Maryland		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Thomas Ford			14. MOTHER'S MAIDEN NAME Ella Landon		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Mr. Marion Crosby, 7711 Old Harford Road			ADDRESS		

18. X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary artery disease DUE TO Diabetes DUE TO		INTERVAL BETWEEN ONSET AND DEATH 4 years 10 years
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IF PART I OR PART II		19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from Nov 29, 1955 to Nov 29, 1955 , that (I) (we) last saw the deceased alive on Nov 29, 1955 , and that death occurred at 11:30 A.M. , from the causes and on the date stated above.				
23A. SIGNATURE Donald Jandorf ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	23B. ADDRESS 6077 Harford Rd M.D.	23C. DATE SIGNED 11-29-55		
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Dec. 2, 1955	24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE RECEIVED BY LOCAL REGISTRAR 11/30/55	REGISTRAR'S SIGNATURE W. Hedrick	25. FUNERAL DIRECTOR Leonard J. Ruck, 5305 Harford Road #14 ADDRESS		

THIS IS A PERMANENT RECORD. PLEASE TYPE OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information so carefully supplied. Physicians: please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER



Item 18 Film 10490 12-5-55

10495

CERTIFICATE OF DEATH

Reg. Dist. No.

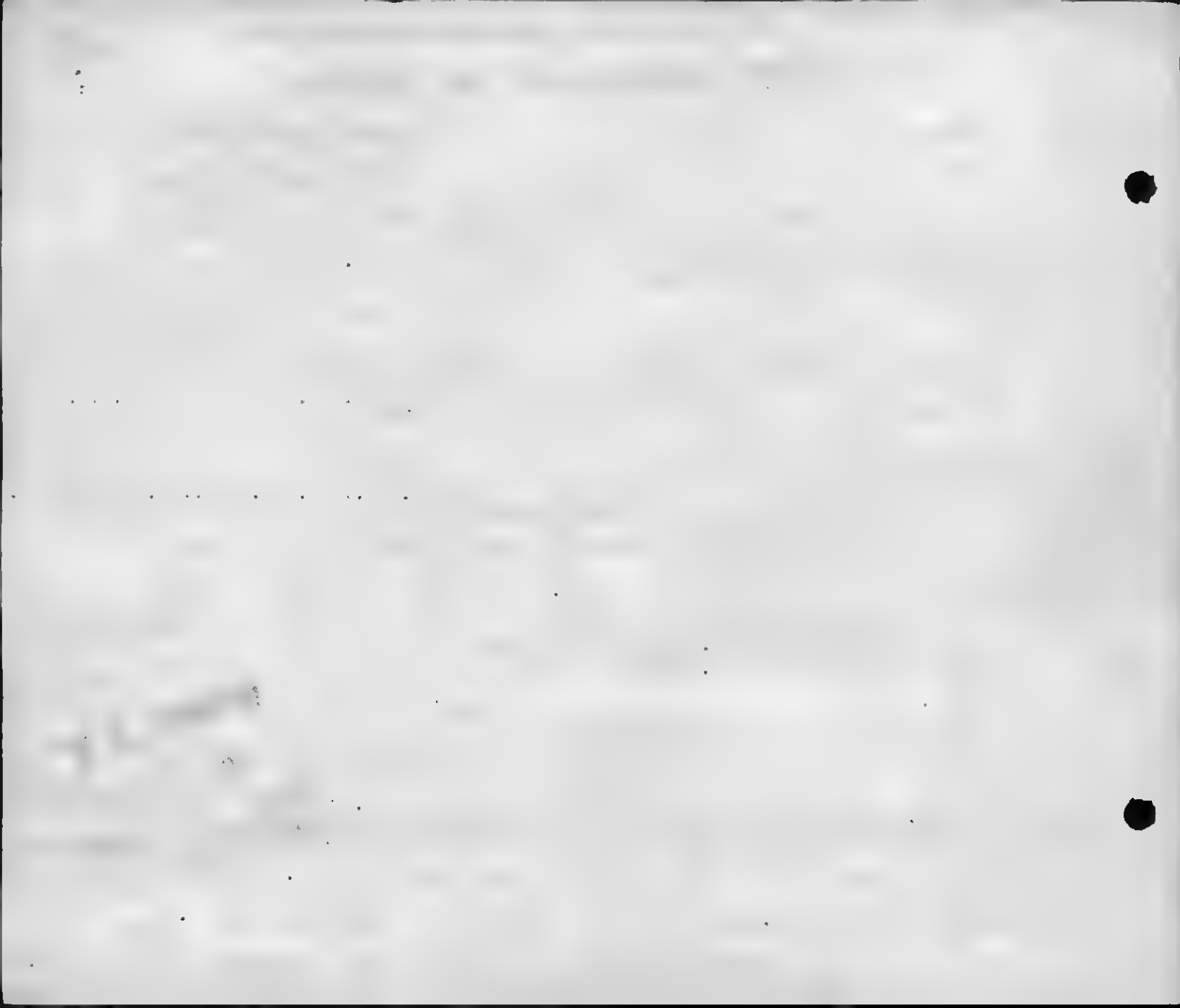
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Fort Howard</u>		<u>89 days</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>3020 E. Fayette Street</u>			
3. NAME OF DECEASED (Type or Print) <u>GEORGE CULBERTSON</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>November 20 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6/27/91</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wood Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Pittsburgh, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Warren Culbertson</u>				14. MOTHER'S MAIDEN NAME <u>Oliba Burton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>216-07-1720</u>		17. INFORMANT & ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
42 IMMEDIATE CAUSE (A) <u>ARTERIOSCLEROTIC HEART DISEASE</u>						Unknown	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
581 (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						10 Years	
1. <u>PARKINSON'S DISEASE</u>							
2. <u>CIRRHOSIS OF THE LIVER</u>							
19a. DATE OF OPERATION <u>Sept. 9, 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>Liver Biopsy revealed Cirrhosis of Liver</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>August 23, 19 55</u> , to <u>Nov. 20, 19 55</u> , that I saw the deceased and that death occurred at <u>12:25 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>George L. Fisher</u>		ADDRESS (Street, city, town, state) <u>Fort Howard, Md.</u>		DATE SIGNED <u>11/20/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 23, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		LOCATION (City, town, or county) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Dawson L. Fisher</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Rick</u>		ADDRESS <u>5905 Hartford Ave Baltimore, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10496

CERTIFICATE OF DEATH

10491

Reg. Dist. No. 40

1. PLACE OF DEATH COUNTY <u>Baldwin</u> MARYLAND CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baldwin Md</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 yrs</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Baldwin</u> CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baldwin Md</u> STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>William H Cursey</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 2 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug 30-1879</u>	9. AGE last birthday <u>76</u> yrs.	10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Chas W. Cursey</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Pocock</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Kalter Jenkins Baldwin Md</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 421.4 IMMEDIATE CAUSE (A) <u>Chronic Valvular Heart</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-sclerosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Arterio-sclerosis</u> STATING UNDERLYING CAUSE LAST. DUE TO (D) <u>Arterio-sclerosis</u>				16. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>12 yrs</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 30, 1950</u> to <u>Nov 2, 1955</u> that I last saw the deceased alive on <u>Oct 2, 1955</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter M. Hammett</u> M.D.				ADDRESS (Street, city, town, state) <u>Baldwin Md</u>			
DATE SIGNED <u>Oct 4-55</u>							
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Nov 5-55</u>		NAME OF CEMETERY OR CREMATORY <u>Wilson M. Ch. Cem</u>		LOCATION (City, town, or county) (State) <u>Towson Md</u>	
24. REC'D BY REGISTRAR <u>Nov 2-1955</u>		REGISTRAR'S SIGNATURE <u>E. E. Arthur</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. E. Arthur</u> ADDRESS <u>Towson Md.</u>			

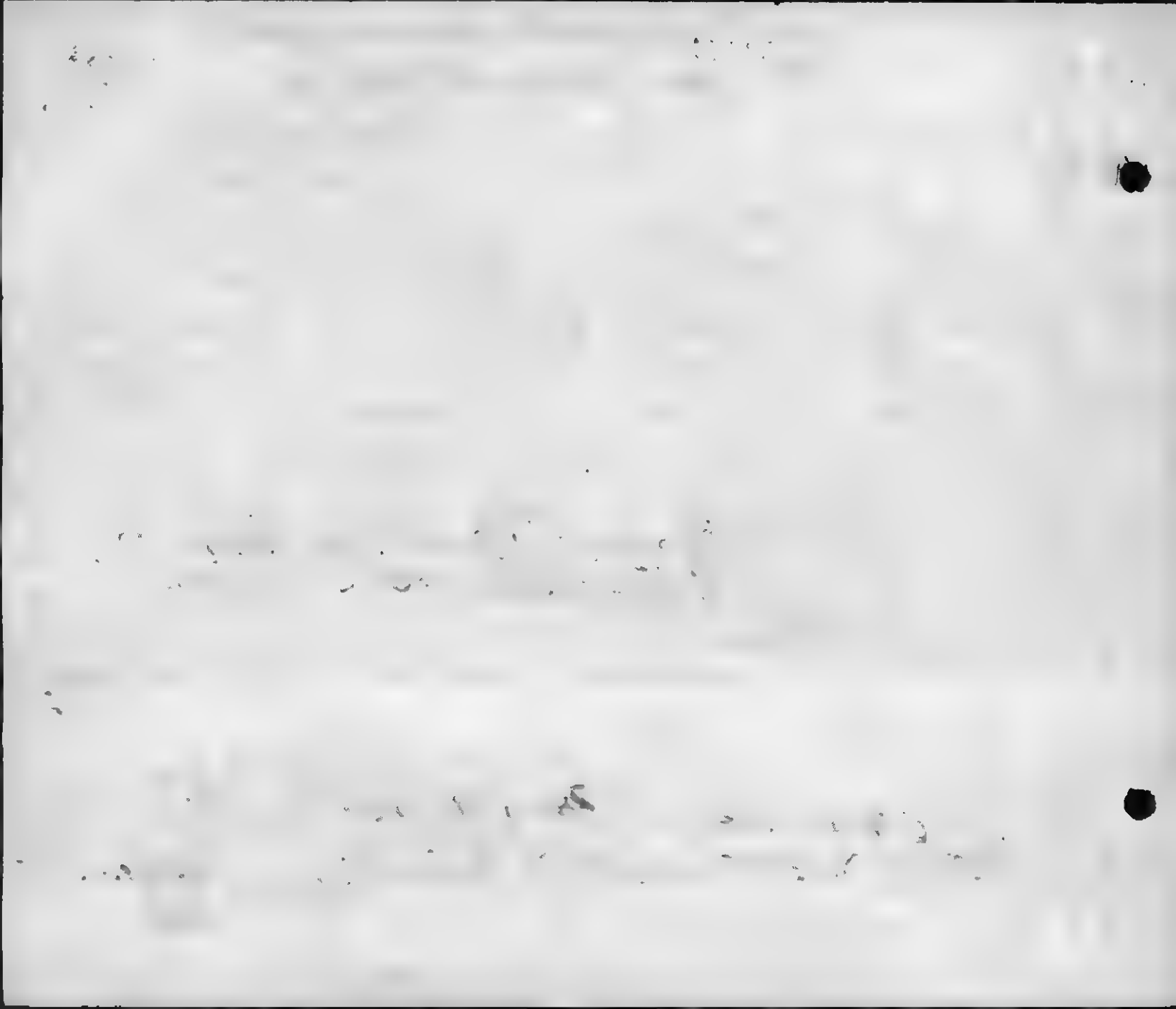
VS A15C 1-55 10M

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

D.F.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10492
10497 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Prince George's</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 Calverville</u>		LENGTH OF STAY (in this place) <u>2 yr. 1 mo. 2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hyattsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove H. Hospital</u>				STREET ADDRESS (If rural give location) <u>Rt. # 1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Mary</u> <u>Curtis</u>				<u>11</u> <u>6</u> <u>1953</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>6-29-1875</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>John H. Crillis</u>				14. MOTHER'S MAIDEN NAME: <u>Harriett Jones</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>1917-18</u>				16. SOCIAL SECURITY No. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hosp.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <u>Terminal bronchopneumonia</u>							
ANTECEDENT CAUSE (B) <u>Arteriosclerotic cardiovascular disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/19</u> , 19 <u>53</u> , to <u>11/6</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>11/6</u> , 19 <u>53</u> , and that death occurred at <u>10: P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Stella Wachser</u>		ADDRESS <u>Spring Grove St. Hosp.</u>		DATE SIGNED <u>11/6/53</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-8-53</u>		NAME OF CEMETERY OR CREMATORY <u>George Washington Park Hyattsville</u>		LOCATION (City, town, or county) (State) <u>11/12</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11/7/53</u>		REGISTRAR'S SIGNATURE <u>T. E. Harvey</u>		24. FUNERAL DIRECTOR <u>Martin W. Hyman</u>		ADDRESS <u>6130 N. St. N.W.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10498

CERTIFICATE OF DEATH

10493

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Catonsville</u>				TOWN <u>Elkton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in Pines 16 Rusting Ave.</u>				STREET ADDRESS (If rural give location) <u>1621 Sulphur Spring Rd.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Robert W. Dailey</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 30/55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 23, 1878</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired File Driver, Raymond</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wesner Dailey</u>				14. MOTHER'S MAIDEN NAME <u>Victoria Morgan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>315 01 2627</u>		17. INFORMANT & ADDRESS <u>Mrs. Rose Mary Jall, 1621 Sulphur Spring Rd</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive A. S. C. V. D.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/6</u> , 19 <u>53</u> , to <u>11/30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/29</u> , 19 <u>55</u> , and that death occurred at <u>12:05</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>John E. Dailey M.D.</u>				ADDRESS (Street, city, town, state) <u>Baltimore, Md</u> DATE SIGNED <u>12/4/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>Dec. 5/55</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>V. E. Barry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Wright</u>		ADDRESS <u>101 Edmondson Ave</u>	
DATE							

2000

DEC

DEC 2000

MARYLAND STATE DEPARTMENT OF HEALTH
10499 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

10394

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Prince George	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Riverdale	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital		STREET ADDRESS (If rural, give location) 4601 Queensbury Road	
3. NAME OF DECEASED (Type or Print) Kenneth Ray		4. DATE OF DEATH (Month) (Day) (Year) November 17, 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 5-27-1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Odd Jobs		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John A. Daugherty		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY No. Unknown	
17. INFORMANT AND ADDRESS Records Spring Grove State Hospital			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) **Cerebrovascular accident**

Antecedent cause(s) (b) **Arteriosclerosis, generalized**

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death **2nd & 3rd degree burns of buttocks and feet**

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Hospital	(CITY OR TOWN) Catonsville (COUNTY) Baltimore (STATE) Md.
TIME (Month) (Day) (Year) (Hour) OF INJURY 11-4-55 7:15A.m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? Unknown

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐

SIGNATURE

Georgie Kieffer MD

ADDRESS

1010 Lee Ave

DATE SIGNED

11-18-55

21. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF Nov. 21, 1955	NAME OF CEMETERY OR CREMATORY Wash. National Cem.	LOCATION (City, town, or county) Suitland, P. G. Co.
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DATE REC'D BY LOCAL REG **11/18/55** REGISTRAR'S SIGNATURE *T.E. Harvey*

24. FUNERAL DIRECTOR

W.W. Chambers ADDRESS **5801 - Chandler Rd. Riverdale Md.**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Reg. Dist. No. 44

MARGIN RESERVED FOR BINDING

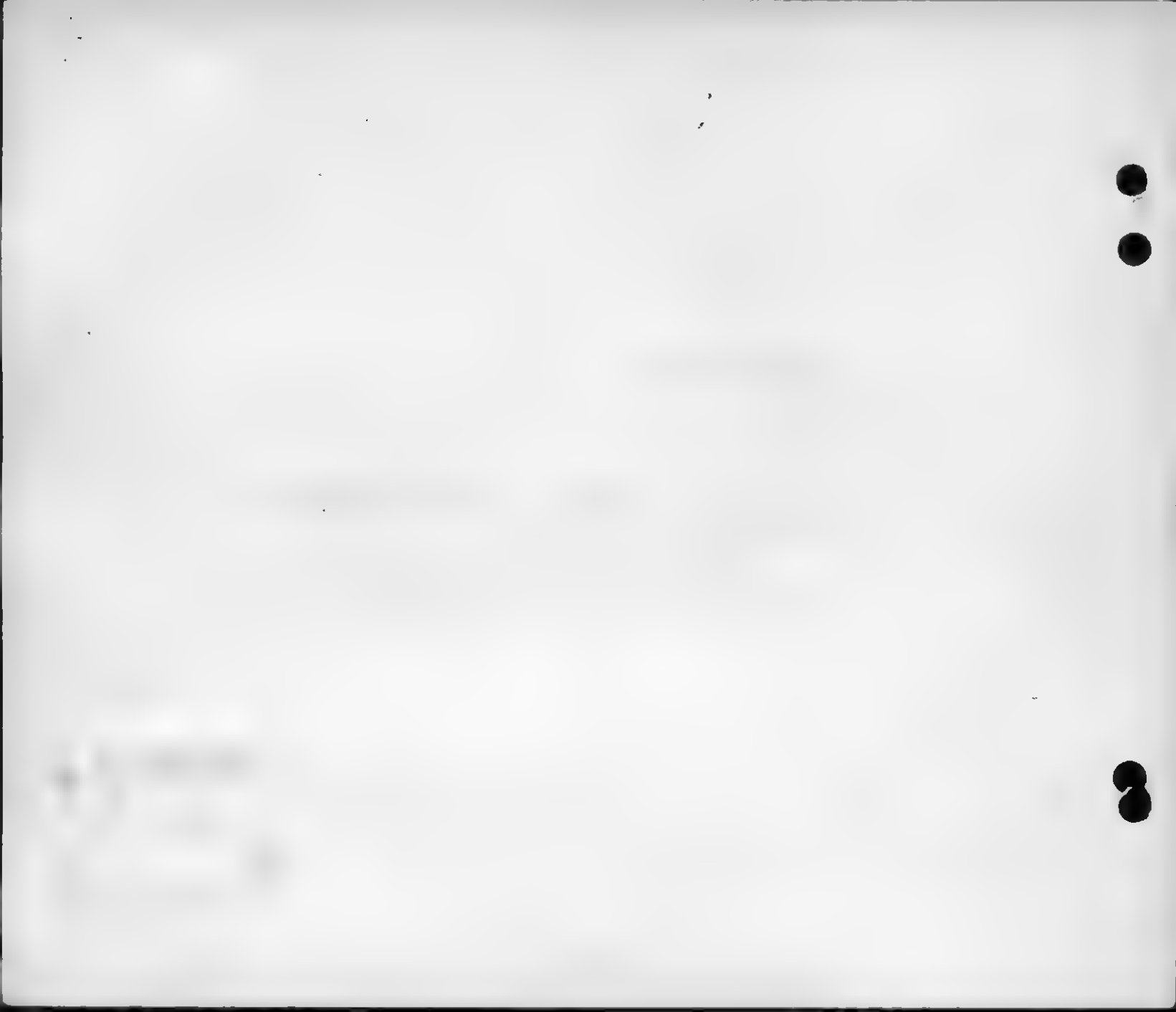
PLEASE WRITE PLAINLY, WITH UNFADING INK—Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY <u>WALTO</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>AG Ce</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN S. Trucons Point</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Rural</u> <u>Elly, Burrell</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14th Street Dispensary</u>				STREET ADDRESS <u>612 Ritchie Highway</u> (If rural, give location) <u>AG Co</u>	
3. NAME OF DECEASED (Type or Print) <u>Erwood</u>		(First) (Middle) (Last) <u>Tavernport</u>		4. DATE OF DEATH (Month) <u>11</u> (Day) <u>2</u> (Year) <u>1942</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>Aug 31-1921</u>		9. AGE last birthday <u>34</u> yrs.		If under 1 year: Months Days Hours Min. If under 24 hrs: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Pitt Co NC</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles Davenport</u>		14. MOTHER'S MAIDEN NAME <u>Rose Hathway</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>612 Ritchie</u> <u>Mathis Davenport</u> <u>Hydco AG Co</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
1. Immediate cause Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last		2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		20. AUTOPSY	
TIME (Month) (Day) (Year) (Hour) OF INJURY PLACE (Home, farm, factory, street, office, etc.) OF INJURY INJURY OCCURRED While at work Not while at work HOW DID INJURY OCCUR?		(CITY OR TOWN) (COUNTY) (STATE) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, or thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE		DATE SIGNED	
23. BURIAL, CREMATION REMOVAL (Specify)		24. FUNERAL DIRECTOR	
DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE		ADDRESS	

VS. A15A



10501 CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rosedale</u>		<u>Life</u>		TOWN <u>Rosedale</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8344 Old Philadelphia Rd.</u>				STREET ADDRESS (If rural give location) <u>8344 Old Philadelphia Rd.</u>			
3. NAME OF DECEASED (Type or Print) <u>Margaret A. Davis</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 28, 1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 16, 1888</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Bohlen</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Moore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Fred J. Davis-8326 Old Phila. Rd.</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u>				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Coronary thrombosis with myocardial infarction</u>						<u>10 minutes</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>9.2.1</u>				(B) <u>Hypertensive + arteriosclerotic CVD</u>			
(C) <u>Diabetes mellitus</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>28 Nov., 1955</u> , to <u>28 Nov., 1955</u> , that I last saw the deceased alive on <u>28 Nov., 1955</u> , and that death occurred at <u>10 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>G. A. Allee</u>				ADDRESS (Street, city, town, state) <u>M.D. 13 E. Eager St - Baltimore - 2, Md.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>12-2-55</u>		NAME OF CEMETERY OR CREMATORY <u>Zion Lutheran</u>		LOCATION (City, town, or county) (State) <u>Balto. County, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Dec 5 1955</u>		REGISTRAR'S SIGNATURE <u>Mrs. Edith Furley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

REC-7

DEC 5

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10496

10502 CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>		CITY <u>Baltimore - Lakeland</u>		CITY <u>Baltimore - Lakeland</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		TOWN <u>Baltimore - Lakeland</u>		TOWN <u>Baltimore - Lakeland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS		STREET ADDRESS		STREET ADDRESS	
2611 Smith Avenue		2611 Smith Avenue		2611 Smith Avenue		2611 Smith Avenue	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
HAZEL L. DOLLE				Nov. 9, 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
female	white	married	March 24, 1900	55 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
housewife		at home		Baltimore, Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George Colhouer				Maggie Michael			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
(If Yes, give war or dates of service)						Fred C. Dolle, 2611 Smith Avenue	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
174X IMMEDIATE CAUSE (A)				Carcinoma of the breast			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		INTERVAL BETWEEN ONSET AND DEATH	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		3 years	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 7, 1955</u> to <u>Nov 9, 1955</u> , that I last saw the deceased alive on <u>Nov 7, 1955</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Samuel Schimpf</u> M.D.				ADDRESS (Street, city, town, state) <u>1101 11th St. Baltimore, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
burial		11/12/55		Lorraine Cemetery		Woodlawn, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Nov. 14, 1955</u>		<u>Dorothy Twells</u>		<u>Wm. Cook Inc.</u>		1217 St. Paul St.	

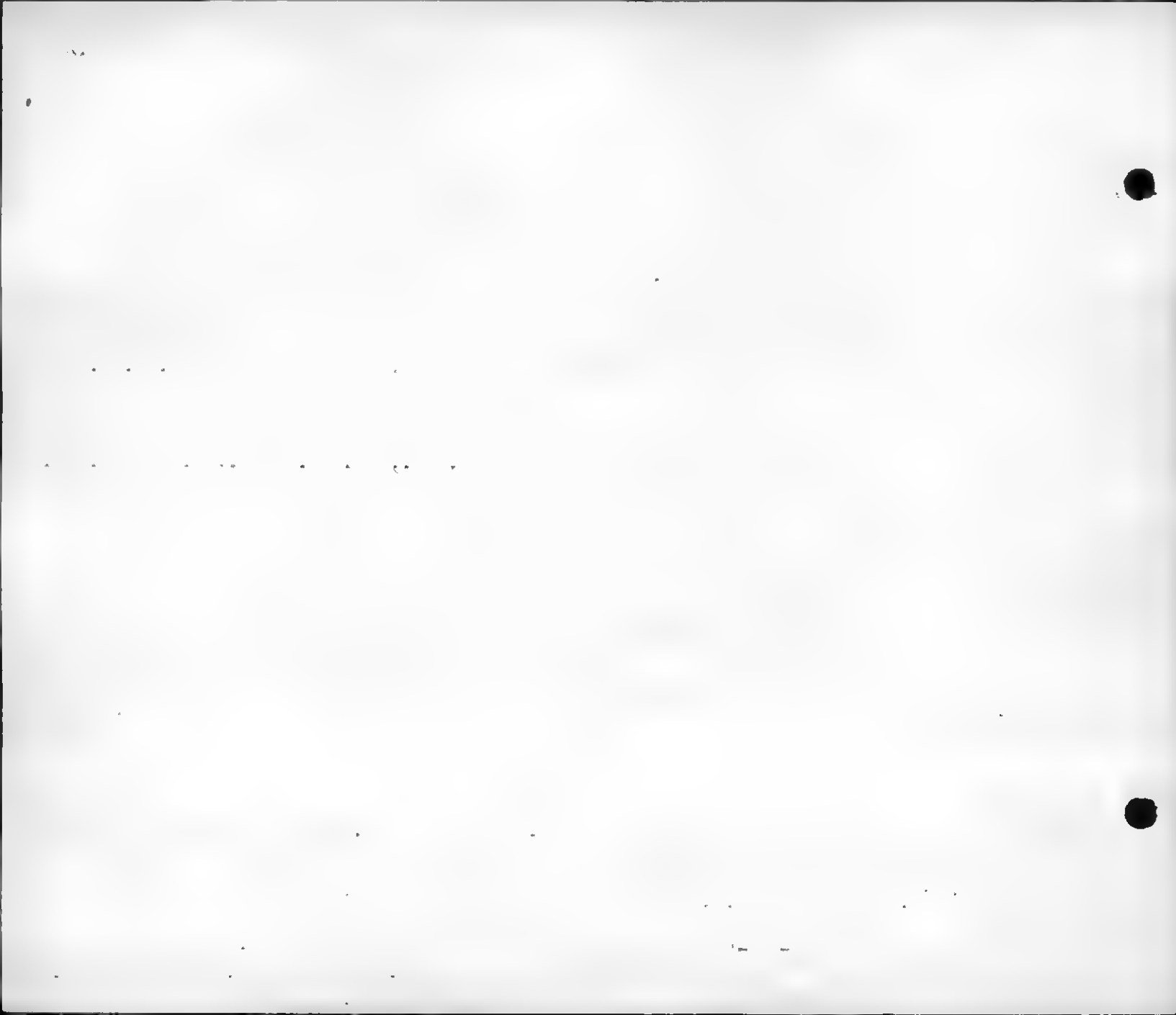


CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Fort Howard</u>		LENGTH OF STAY (in this place) <u>9 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>2007 East Fairmont Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>LESTER G. DUNPHY</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>November 18 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>3-20-97</u>	
9. AGE last birthday <u>58</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet Maker</u>		11. KIND OF BUSINESS OR INDUSTRY: <u>Furniture Factory</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Thomas Dunphy</u>				14. MOTHER'S MAIDEN NAME: <u>Barbara Tribett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Clin.Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						UNKNOWN	
IMMEDIATE CAUSE (A) <u>UNCONTROLLABLE DIABETES MELLITUS</u>							
ANTECEDENT CAUSE (B) <u>RESECTION OF LOWER SIGMOID AND UPPER RECTUM FOR CARCINOMA (DURATION OF CARCINOMA)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						2 Months	
19A. DATE OF OPERATION: <u>11-3-55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Resection Sigmoid End to End Anastomosis</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 9, 1955, to Nov. 18, 1955, and that death occurred at 3:55 AM, from the causes and on the date stated above.							
SIGNATURE OF REGISTRAR: <u>WILLIAM B. VANDEGRIFT, M.D.</u>				ADDRESS: <u>M. OVAH, FORT HOWARD, MARYLAND</u> DATE SIGNED: <u>11-18-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11-22-55</u>		<u>Baltimore National</u>		<u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>11-18-55</u>		REGISTRAR'S SIGNATURE: <u>W. B. Vandegrift</u>		24. FUNERAL DIRECTOR: <u>H. John A. Moran</u>		ADDRESS: <u>3000 E. Baltimore Str. Baltimore, Maryland</u>	

MARGIN RESERVED FOR BINDING



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CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>2nd</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		LENGTH OF STAY (in this place) <u>3.0</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2 Sudbrook Ave</u>				STREET ADDRESS (If rural give location) <u>2 Sudbrook Ave.</u>		<u>1</u>	
3. NAME OF DECEASED: (First) <u>Mary</u> (Middle) <u>Cecilia</u> (Last) <u>East</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>NOV 8 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH: <u>Aug 11, 1898</u>	
9. AGE last birthday: <u>57</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>Vincent Zito</u>		14. MOTHER'S MARDEN NAME: <u>Rose Caniota</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Josephine East 2 Sudbrook, Pikesville, Md</u>		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma of ovary with metastases 1 yr</u>		DUE TO					
ANTECEDENT CAUSE (B)		DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>18 May 55</u>		19b. MAJOR FINDINGS OF OPERATION: <u>Carcinoma of ovary with metastases</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr 1953</u> , to <u>8 Nov, 1955</u> , that I last saw the deceased alive on <u>7 Nov, 1955</u> , and that death occurred at <u>2:50 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Paul H. Rayse</u>		ADDRESS <u>Pikesville 8 Rd</u>		DATE SIGNED <u>8 Nov 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>Nov 11, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Wood Ridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Pikesville Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>NOV 10, 1955</u>		REGISTRAR'S SIGNATURE <u>Dorothy A. Newell</u>		24. FUNERAL DIRECTOR <u>Frank J. Newell</u>		ADDRESS <u>Pikesville</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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1. 16

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10505

CERTIFICATE OF DEATH

Reg. Dist. No. 45

I. PLACE OF DEATH:

COUNTY Balto. MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR
 TOWN Westertown LENGTH OF STAY (in this place)
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Sorenson Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md COUNTY Balto.
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR
 TOWN Baltimore (If rural, give location)
 STREET ADDRESS 114 N. Janney St.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

HENRYEBERLING

4. DATE OF DEATH:

(Month)

(Day)

(Year)

Nov 301955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED,

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MWWidowedOct 25 - 188273 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

MechanicBeth-SteelBalto. Md.U.S.A.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

Geo. EberlingGilbert

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

(Yes, no, or unk.) (If Yes, give war or dates of service)

7308 HolabirdBalto.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO

(a) Coronary Thrombosis(b) Arteriosclerosis Cerebral(c) hemorrhage 1951

INTERVAL BETWEEN ONSET AND DEATH

10 minutesyears

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/27/55 to 11/30/55, that I last saw the deceased alive on 11/27/55, and that death occurred at 9:45 P.M. from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Burial12-5-55Trinity Cem.Balto.Md.12/2/55Earl HueyJohn G. ConnellyEssex, Md.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. GOVERNMENT

OFFICE

10506

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MD</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Catonsville</u>				TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>House in the Pines</u>				<u>1251 N Luzerne Ave</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>SARAH</u>		(Middle) <u>E.</u>		(Last) <u>EPPLEY</u>		(Month) (Day) (Year)	
						<u>November 10/55</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR IF UNDER 24 HRS.		
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>Dec 18 1877</u>	<u>77</u>	yrs.	Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
		<u>at home</u>		<u>Baltimore</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Don't know</u>				<u>Don't know</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Melvin Eppley 1251 N Luzerne Ave</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Ch. Hypertensive Cardio-Vascular Disease</u>						<u>1 da.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)						<u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-9</u> , 19 <u>55</u> , to <u>11-10</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11-10</u> , 19 <u>55</u> , and that death occurred at <u>6 P.</u> M., from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Melvin K. Gallager</u>				<u>M.D. 6204 Frederick Rd. Balt 28, Md.</u>		<u>11/11/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>burial</u>		<u>Nov 14/55</u>		<u>Loudon Park</u>		<u>Baltimore</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Nov. 15, 1955</u>		<u>Victor E. Harris</u>		<u>Ullrich Funeral Home 4210 Belair Road</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

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RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10501

10507

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>Calverton</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Calverton</u> MD TOWN <u>Calverton</u> MD HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE _____ COUNTY _____ CITY (If outside corporate limits, write RURAL and give nearest town) <u>Calverton</u> MD TOWN <u>Calverton</u> MD STREET ADDRESS <u>Madison Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>Thelma Jackson Estep.</u>				4. DATE OF DEATH (Month) <u>11</u> (Day) <u>22</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>3/5/1917</u>	9. AGE last birthday <u>38</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>teacher</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Perry Jackson</u>				14. MOTHER'S MAIDEN NAME <u>Francis Jackson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) _____ (If Yes, give war or dates of service) _____			16. SOCIAL SECURITY NO. _____		17. INFORMANT & ADDRESS <u>Hon. Robert Jackson</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 171X IMMEDIATE CAUSE (A) <u>Carcinoma of Cervix</u>						<u>2 years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>metastasis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. _____							
19a. DATE OF OPERATION <u>1953/11</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Cervix</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) _____		21c. WHERE DID INJURY OCCUR? (City or town) _____ (County) _____ (State) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>7/5/55</u> to <u>11/22/55</u> , that I last saw the deceased alive on <u>11/21/55</u> , 19 <u>55</u> , and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>T. E. Jackson</u>				ADDRESS (Street, city, town, state) <u>600 N. Wilmington Ave. Md 11/25/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/26/55</u>		NAME OF CEMETERY OR CREMATORY <u>Hopkins Chapel</u>		LOCATION (City, town, or county) (State) <u>Highland, Md.</u>	
24. REC'D BY REGISTRAR <u>Nov. 29, 1955</u>		REGISTRAR'S SIGNATURE <u>T. E. Jackson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden.</u> ADDRESS <u>Rockville, Md.</u>			



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10453 CERTIFICATE OF DEATH

10502

Reg. Dist. No. 41

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-53 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO.</u>		STATE <u>MD</u>		COUNTY <u>BALTO.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>DUNDALK 22</u>				TOWN <u>DUNDALK 22 (GREY MANOR)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2517 MCCOMAS AVE.</u>				STREET ADDRESS (If rural give location) <u>2517 MCCOMAS AVE.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MAUD</u> (Middle) <u>GRIFFITH</u> (Last) <u>EVANS</u>				(Month) <u>NOV</u> (Day) <u>22</u> (Year) <u>1955</u>			
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>FEB 12, 1881</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>WALES</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS E. GRIFFITH</u>				14. MOTHER'S MAIDEN NAME <u>MADAMAH EVANS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>XXXX</u>		17. INFORMANT & ADDRESS <u>MRS. ALEX. GIBSON - SAME</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
199.1 IMMEDIATE CAUSE (A) <u>Sarcoma.</u>						<u>3 years</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>1952</u>		19b. MAJOR FINDINGS OF OPERATION <u>...</u>				20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 21, 1955</u> to <u>Nov 22, 1955</u> , that I last saw the deceased alive on <u>Nov 21, 1955</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wanda</u>		M.D. <u>6-20 DIST.</u>		ADDRESS (Street, city, town, state) <u>Scranton, PA.</u>		DATE SIGNED <u>11-22-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>11-26-55</u>		NAME OF CEMETERY OR CREMATORY <u>ROBINSON HILLS</u>		LOCATION (City, town, or county) (State) <u>SCRANTON, PA.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>William M. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Andrew Bradley</u>		ADDRESS <u>Dundalk, Md.</u>	
DATE <u>11/25/55</u>							



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10508 CERTIFICATE OF DEATH

10508

Reg. Dist. No. 197

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Victory Villa</u>				TOWN <u>Victory Villa</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>108 YOW METER</u>				STREET ADDRESS (If rural give location) <u>118 YOW METER</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>John</u> (Middle) <u>L</u> (Last) <u>EVERETT</u>				(Month) <u>11</u> (Day) <u>24</u> (Year) <u>53</u>			
5. SEX <u>M</u>	6. CO. OR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWER</u>	8. DATE OF BIRTH <u>DEC-22-1869</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL</u>		11. BIRTHPLACE (State or foreign country) <u>Morgan Co. W. Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John H. EVERETT</u>				14. MOTHER'S MAIDEN NAME <u>MARY E. ALLEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>JAMES R. EVERETT, Victory Villa 118 YOW METER</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						24 hrs	
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, generalized</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		2 (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/17</u> , 19 <u>55</u> , to <u>11/21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/21</u> , 19 <u>55</u> , and that death occurred at <u>8 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Joseph Lawrence</u>		M.D.		ADDRESS (Street, city, town, state) <u>30 Chandler Rd. Balt. Md.</u>		DATE SIGNED <u>11/24/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>11/29/55</u>		NAME OF CEMETERY OR CREMATORY <u>GREEN WAY</u>		LOCATION (City, town, or county) (State) <u>BERKELEY SPGS. W. Va.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>John B. Longfellow</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>ELI HIGGINS</u>		ADDRESS <u>11130 THOM, ELLIOTT CITY MD</u>	
DATE <u>11-26-55</u>							



10509 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Middle River</u> LENGTH OF STAY (in this place)				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Middle River</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 73, Route 16, Bird River Road</u>				STREET ADDRESS (If rural give location) <u>Box 73, Route 16, Bird River Road</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>ELIZABETH A. FISCHER</u>				OF DEATH <u>Nov. 30, 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>May 19, 1890</u>	
9. AGE last birthday <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10B. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday IF UNDER 1 YEAR: Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country): <u>Germany</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME: <u>Don't know</u>				14. MOTHER'S MAIDEN NAME: <u>Ida Gassner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service) <u>No.</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT & ADDRESS: <u>Andrew J. Miller 3120 Woodhome Ave.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Metastatic carcinoma uterus</u>						<u>2 years</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>1954</u>				19B. MAJOR FINDINGS OF OPERATION: <u>Carcinoma uterus</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21C. WHERE DID (City or town) (County) (State)				21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 4, 1954</u> , to <u>Nov 30, 1955</u> , that I last saw the deceased alive on <u>Nov 30, 1955</u> , and that death occurred at <u>10:40 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Louis Semenov</u>				ADDRESS <u>M. D. 14322 Furlong Ave, Balt 20 Md</u>			
DATE SIGNED <u>12/1/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>Dec. 3, 1955</u>			
NAME OF CEMETERY OR CREMATORY <u>Zion Evan. Lutheran</u>				LOCATION (City, town, or county) (State) <u>Stemmers Run, Md.</u>			
DATE REC'D BY LOCAL REGISTRAR <u>12/6/55</u>				REGISTRAR'S SIGNATURE <u>A. J. Adrich</u>			
24. FUNERAL DIRECTOR <u>W. Ullrich Funeral Home</u>				ADDRESS <u>4210 Belair Road.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

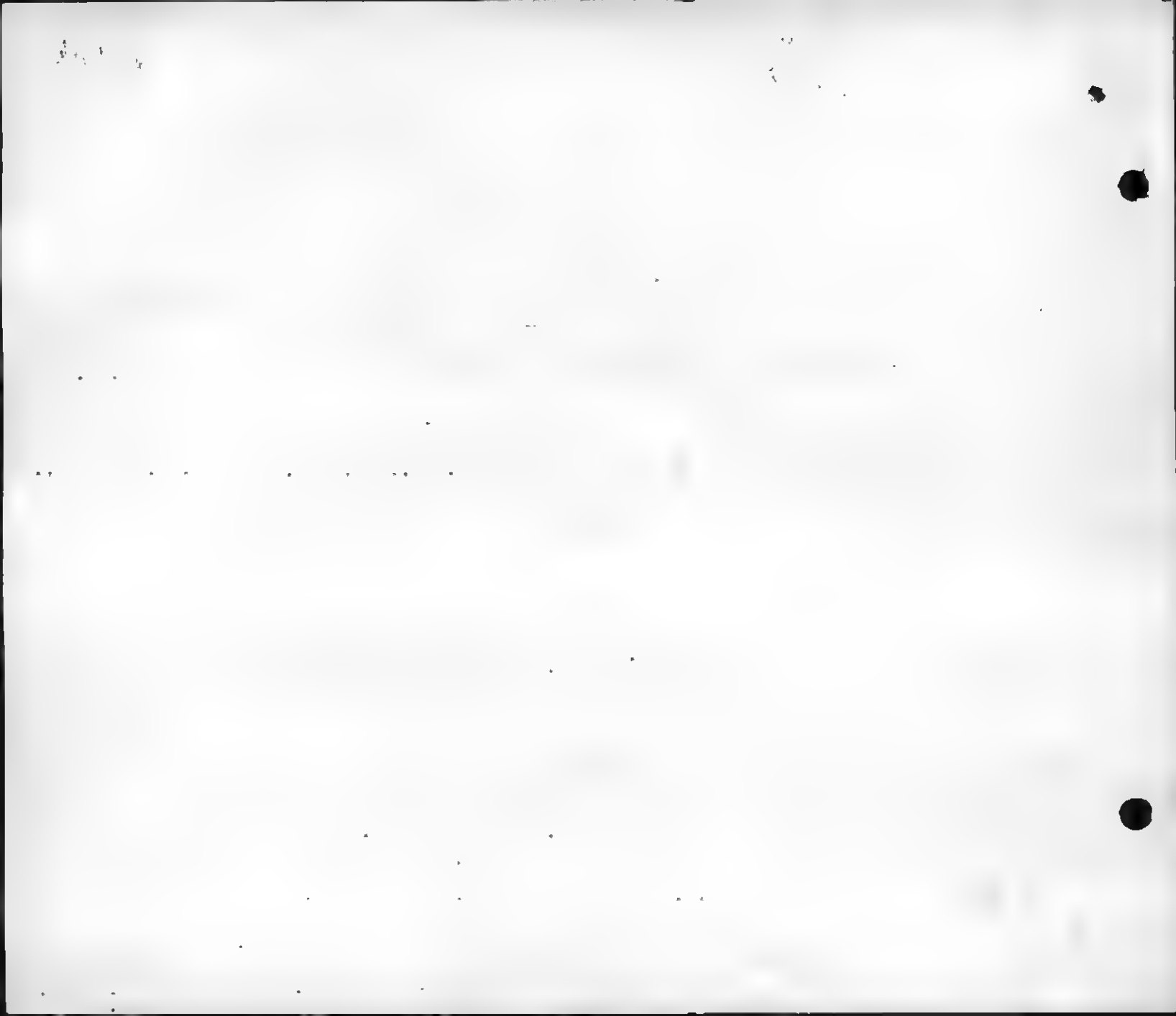
10510

CERTIFICATE OF DEATH

Reg. Dist. No. 4

10505

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fort Howard</u>		98 Days		OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>4920 Denmore Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH			
<u>EUGENE J. FISHER</u>				<u>November 29 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>4-19-90</u>	<u>65</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Occupational Therapist</u>		<u>Hospital</u>		<u>Front Royal, Virginia</u>		<u>U. S. A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Cyrus Fisher</u>				<u>Mary E. McCuen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<u>Yes</u> <u>WW I</u>				<u>043-14-9582</u>			
				17. INFORMANT & ADDRESS:			
				<u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CARCINOMA OF LEFT LUNG</u>						<u>UNKNOWN</u>	
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH						<u>Unknown</u>	
<u>(1) Emphysema, Pulmonary (2) Benign Prostatic Hypertrophy. (3) Erosive esophagitis</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 23, 1955</u> , to <u>Nov. 29, 1955</u> , and that death occurred at <u>8:40 PM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Irving Freeman</u>		<u>M. D. VAH, FORT HOWARD, MARYLAND</u>		<u>12-1-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>DEC. 5, 1955</u>		<u>Baltimore National</u>		<u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>12/5/55</u>		<u>Wm. Cook-Blight, Inc.</u>		<u>6009 Harford Rd. Balto.</u>		<u>Md.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1810507
10463 CERTIFICATE OF DEATH

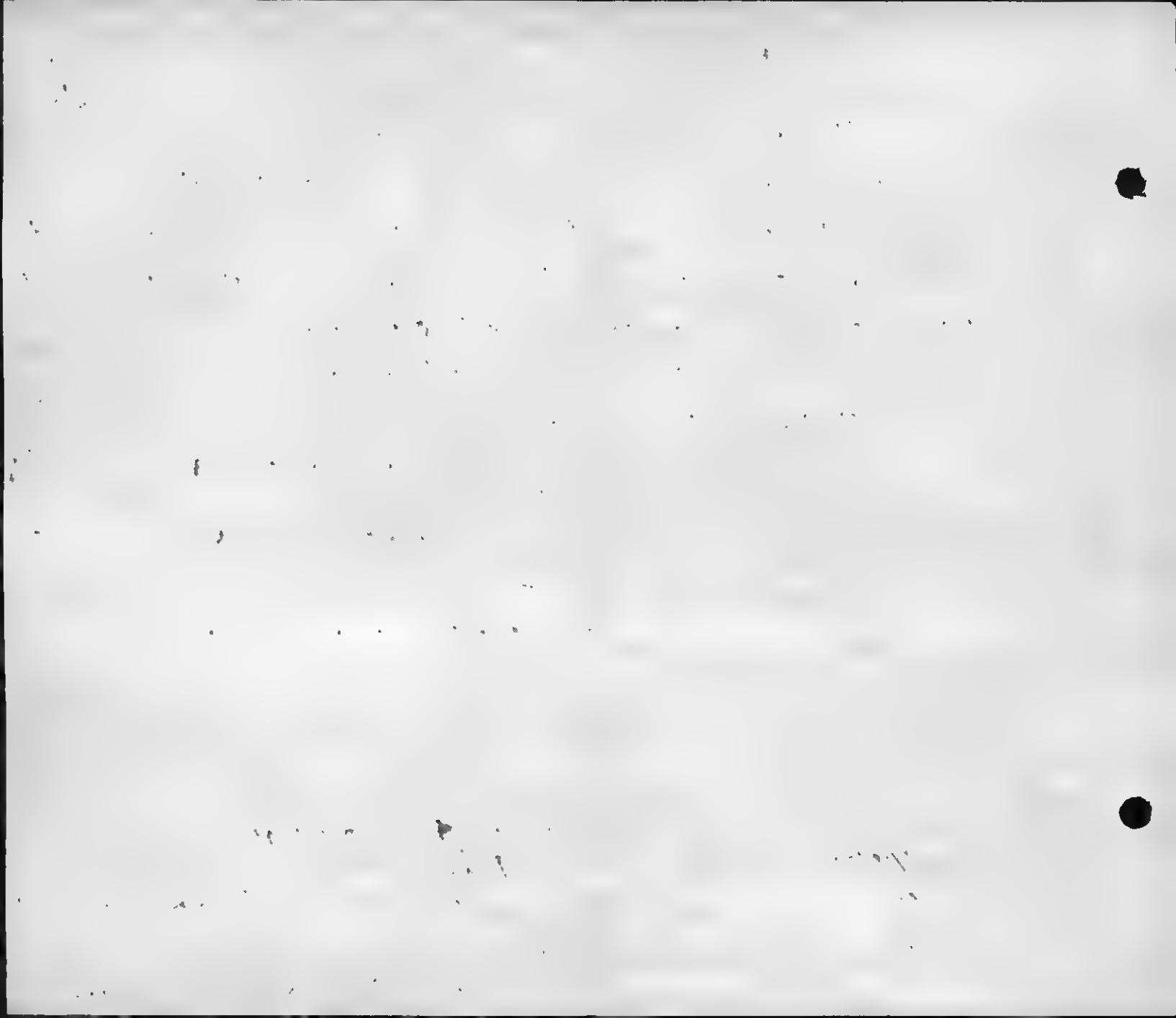
Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Arbutus</u>	LENGTH OF STAY (in this place) <u>Life</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Arbutus</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1108 Sulphur Sp Rd</u>		STREET ADDRESS (If rural give location) <u>1108 Sulphur Sp Rd</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Snowden</u> <u>Fletcher</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>Nov 12 1953</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>July 8 - 1872</u>
9. AGE last birthday <u>83</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Mitchellville Md</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): <u>Barber</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Edward Fletcher</u>		14. MOTHER'S MAIDEN NAME: <u>Mary ? (unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY NO. <u>1108 Sulphur Sp Rd</u>	
17. INFORMANT & ADDRESS: <u>Sarah Bruce Arbutus 27 Md</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
4-2-51 IMMEDIATE CAUSE (A) <u>Chr Myocarditis</u>		<u>4 mo</u>	
ANTECEDENT CAUSE (B) <u>General arteriosclerosis</u>		<u>5 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>a infirmities 2 age 1 yr</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>11</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb. 1953</u> , to <u>Nov 1953</u> , that I last saw the deceased alive on <u>Nov 11, 1953</u> , and that death occurred at <u>9 42 M.</u> from the causes and on the date stated above.			
SIGNATURE <u>D. B. B. Cunningham</u>		DATE SIGNED <u>11/12/53</u>	
ADDRESS <u>M.D. 7609 Main St Elkhart 27 Ind</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 16, 1953</u>	
NAME OF CEMETERY OR CREMATORY <u>Western Star</u>		LOCATION (City, town, or county) (State) <u>Catsville, Ind</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11/14/53</u>		REGISTRAR'S SIGNATURE <u>A. W. H. H. H.</u>	
24. FUNERAL DIRECTOR <u>W. H. H. H.</u>		ADDRESS <u>1031 S. Main St Elkhart 27 Ind</u>	

MARGIN RESERVED FOR FINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



10511 CERTIFICATE OF DEATH

10508

Reg. Dist. No. 49

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fullerton</u>		Life		TOWN <u>Fullerton</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
80 <u>7806 Belair Rd.</u>				<u>7806 Belair Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Mary</u> (Middle) <u>A.</u> (Last) <u>Forster</u>				(Month) <u>Nov.</u> (Day) <u>29,</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>Aug. 14, 1875</u>	<u>80</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>At Home</u>		<u>Balto. County, Maryland.</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Rosengarn</u>				<u>Caroline Gegner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mrs. S. R. Solomon-7806 Belair Rd.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
445X IMMEDIATE CAUSE (A) <u>Pulmonary Edema</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardio-Vascular Hypertensive Disease</u>				<u>1 day</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arteriosclerosis</u>				<u>5 yrs.</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>5 yrs.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 1950</u> to <u>29 Nov., 1955</u> , that I last saw the deceased alive on <u>29 Nov., 1955</u> , and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Michael J. Dausch</u>				<u>M.D. 4636 Belair Road</u>		<u>11/30/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>12-2-1955</u>		<u>Zion Lutheran</u>		<u>Balto. County, Maryland.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>12-2-1955</u>		<u>Mrs. A. L. Kasper</u>		<u>Lassahn Funeral Home - 7401 Belair Rd.</u>			

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUMBAU V. S.

DEC 1 1953

INT. SEC. DIV.

10512

CERTIFICATE OF DEATH

Reg. Dist. No. 10509

1. PLACE OF DEATH:

COUNTY BALTO. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) ESSEX LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS SORENSEN NURSING HOME

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD COUNTY BALTO
CITY (If outside corporate limits, write RURAL and give nearest town) ESSEX OR TOWN 54
STREET ADDRESS (If rural, give location) 110 HOMBERG AVE

3. NAME OF DECEASED: (First) (Middle) (Last)
MICHAEL H GERBER
4. DATE OF DEATH: (Month) (Day) (Year)
111 101 19 55
5. SEX: M 6. COLOR OR RACE: W 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M 8. DATE OF BIRTH: 4/11/1871 9. AGE last birthday: 84 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TYPE FLITER 10b. KIND OF BUSINESS OR INDUSTRY: BALTO COPPER 11. BIRTHPLACE (State or foreign country): CHICAGO ILL. 12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: NICHOLAS GERBER 14. MOTHER'S MAIDEN NAME: SAMF AS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) 16. SOCIAL SECURITY No.: 17. INFORMANT & ADDRESS: MAGGIE GERBER ANNE

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

148X
Immediate cause (a) metastatic Carcinoma of the
DUE TO Antecedent cause(s) (b) Adenocarcinoma Throat
DUE TO Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) Advancing years.

INTERVAL BETWEEN ONSET AND DEATH

few days.

5 yrs.

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

none. none

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
SUICIDE no INJURY no

TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED HOW DID INJURY OCCUR?
OF INJURY no injury & M. While at work ☐ Not while at work ☐

22. I hereby certify that I attended the deceased from Nov. 1st, 1955, to Nov. 12, 1955, that I last saw the deceased alive on Nov. 6th, 1955, and that death occurred at 8:30 P.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED
James Graham McClinton, MD 516 Cathedral Street 11-14-55

23. BURIAL, CREMATION REMOVAL (Specify): DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)
INTERIAL 11/14/55 CAK LAWN BALTO. MD

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS
REG. John G. Connelly Essex

md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

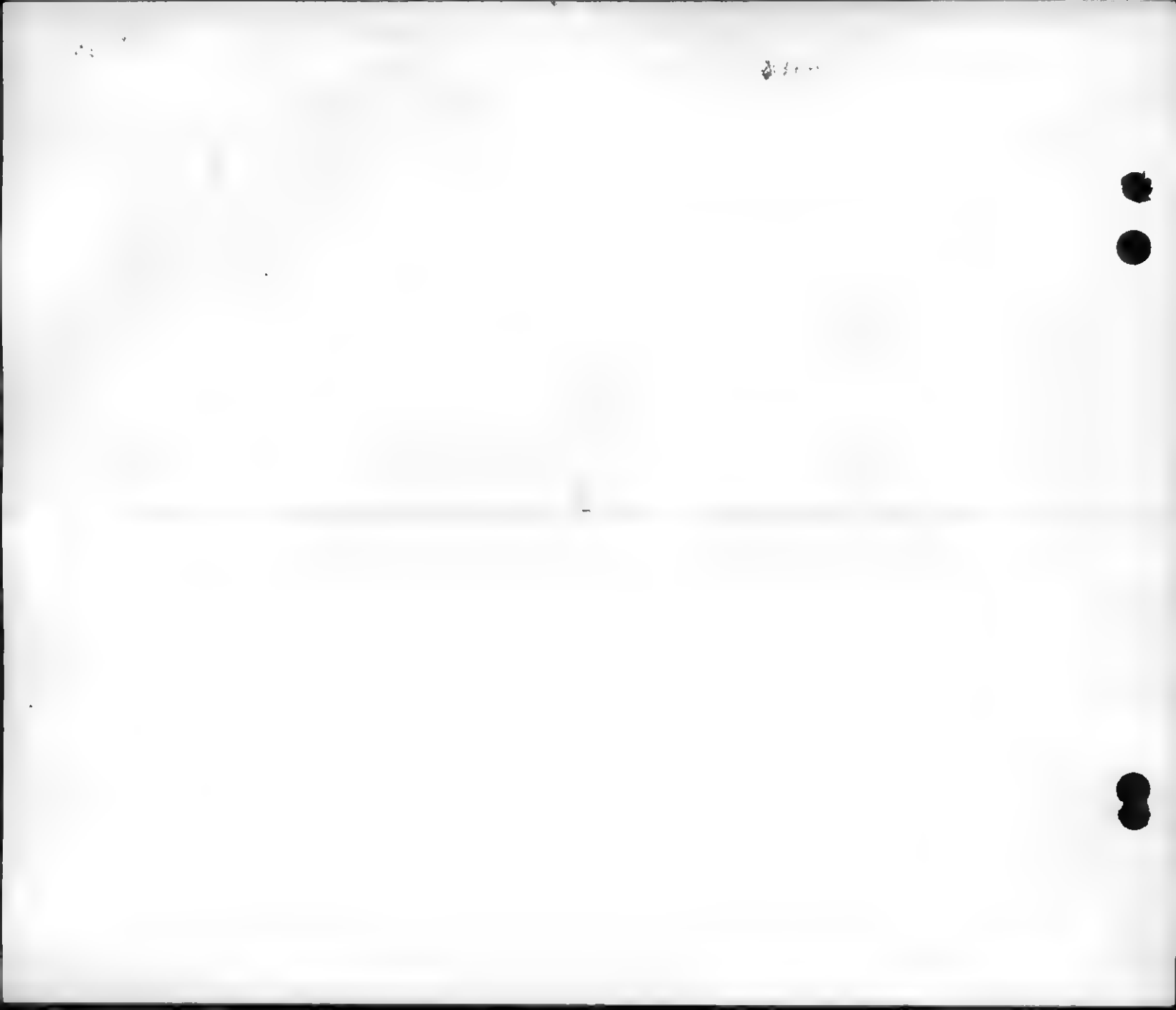
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1810510

10513 CERTIFICATE OF DEATH

Reg. Dist. No.

Item 7. Film G189 11-21-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore-19</u> MARYLAND				STATE <u>Md.</u> COUNTY <u>Balto</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Sparrows Pt.</u>		<u>18 mo.</u>		TOWN <u>as in</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2525 Lyncamore Ave.</u>				STREET ADDRESS (If rural, give location) <u># 1.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>GUS</u> <u>GIBBS</u>				OF <u>Nov.</u> <u>18</u> <u>1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>?</u>	
9. AGE last birthday: <u>85</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>General</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>				13. FATHER'S NAME: <u>Unknown</u>			
14. MOTHER'S MAIDEN NAME: <u>Unknown</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>NO</u> (If Yes, give war or dates of service)			
16. SOCIAL SECURITY No.: <u>None</u>				17. INFORMANT & ADDRESS: <u>Nannul Swann</u> <u>Address as in # 1 -</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
422.1 Immediate cause (a) <u>Chronic Severe myocarditis</u>						<u>12 yrs.</u>	
Antecedent cause(s) (b) <u>Atherosclerosis</u>						<u>12 yrs.</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 16</u> , 19 <u>55</u> , to <u>Nov. 18</u> , 19 <u>55</u> that I last saw the deceased alive on <u>Nov. 16</u> , 19 <u>55</u> and that death occurred at <u>5:30 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Loene H. Pollin</u>				DEGREE OR TITLE <u>med. 6908 North Pt. Rd Balto-19</u>		DATE SIGNED <u>Nov. 18/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>11-22-55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		LOCATION (City, town, or county) (State) <u>A. A. Co. Md.</u>	
DATE REC'D BY LOCAL REG. <u>11-18-55</u>		REGISTRAR'S SIGNATURE <u>G. W. Hedrick</u>		24. FUNERAL DIRECTOR <u>Samuel M. Sullivan Jr</u>		ADDRESS <u>1011 N. Arlington Ave Balto</u>	



10464

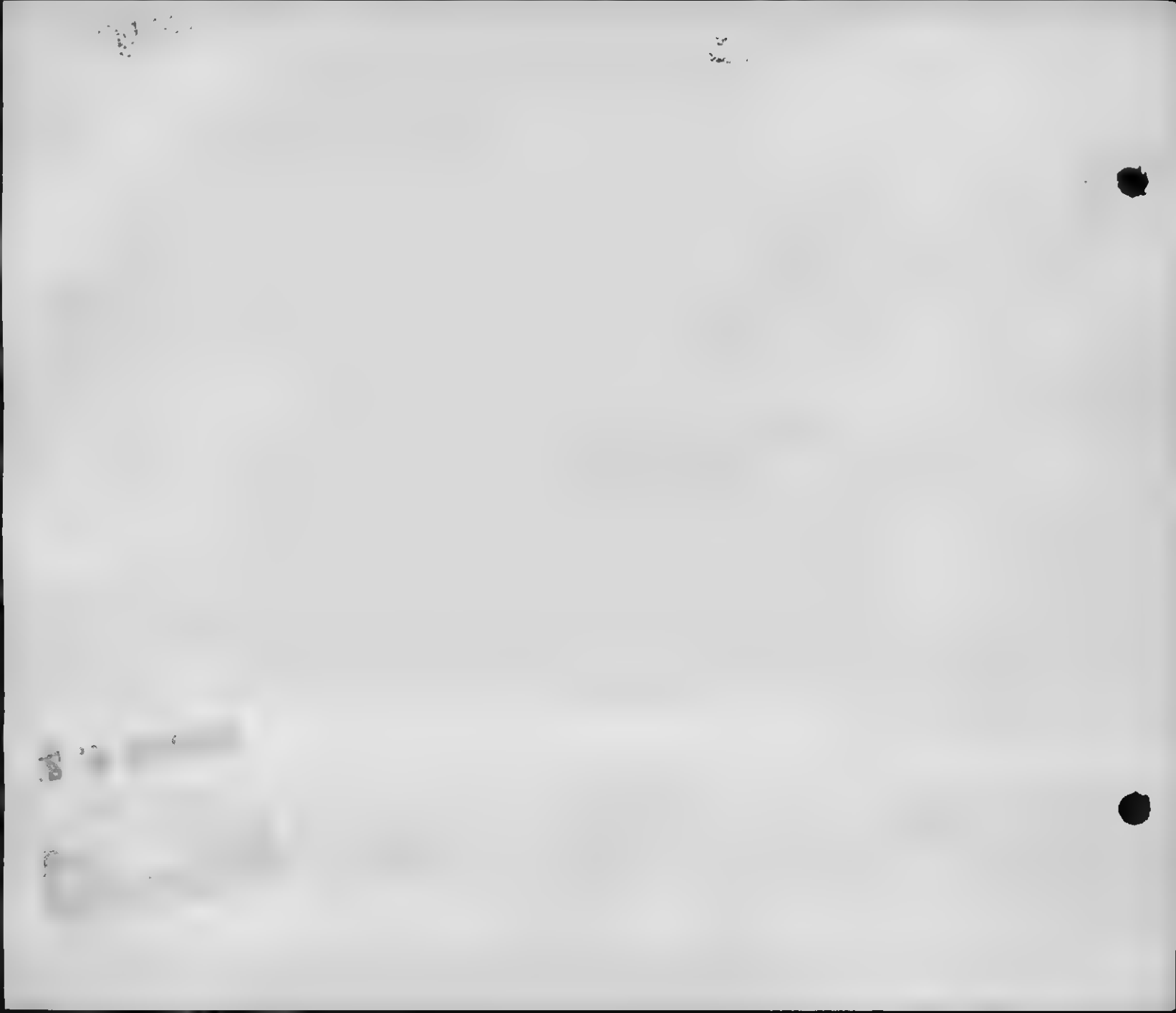
10511
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 42

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balt</u>	MARYLAND	STATE <u>md</u> COUNTY <u>Balt</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>51</u> <u>Arbutus</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town) <u>51</u> <u>Arbutus</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5370 Fink an</u>		STREET ADDRESS <u>5370</u> (If rural, give location) <u>Fink an</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Helen</u>	(Middle) <u>Mary</u>	(Last) <u>Gibson</u>	(Month) <u>Nov</u> (Day) <u>27</u> (Year) <u>1953</u>
5. SEX: <u>7</u>	6. COLOR OR RACE: <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Aug 26 1898</u>
9. AGE last birthday: <u>57</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country): <u>Balt md.</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>John S. Shields</u>		14. MOTHER'S MAIDEN NAME: <u>Frances</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>1229</u>	
17. INFORMANT & ADDRESS: <u>Audrey Shue</u>		<u>Bural an</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>420.1</u> Immediate cause (a)..... <u>Crownay thrombosis</u> DUE TO Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c).....		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>Dr. M. Kieffer</u> 1010 Leiden		
CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Nov 28 53</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>11-30-53</u>	NAME OF CEMETERY OR CREMATORY: <u>New Cathedral Cem</u>
LOCATION (City, town, or county) (State): <u>Balt md</u>	24. FUNERAL DIRECTOR: <u>Dr. Cook Inc</u>	
DATE REC'D BY LOCAL REG: <u>Nov 28 53</u>	REGISTERAR'S SIGNATURE: <u>Dr. Kieffer</u>	ADDRESS: <u>1217 St Paul st</u>



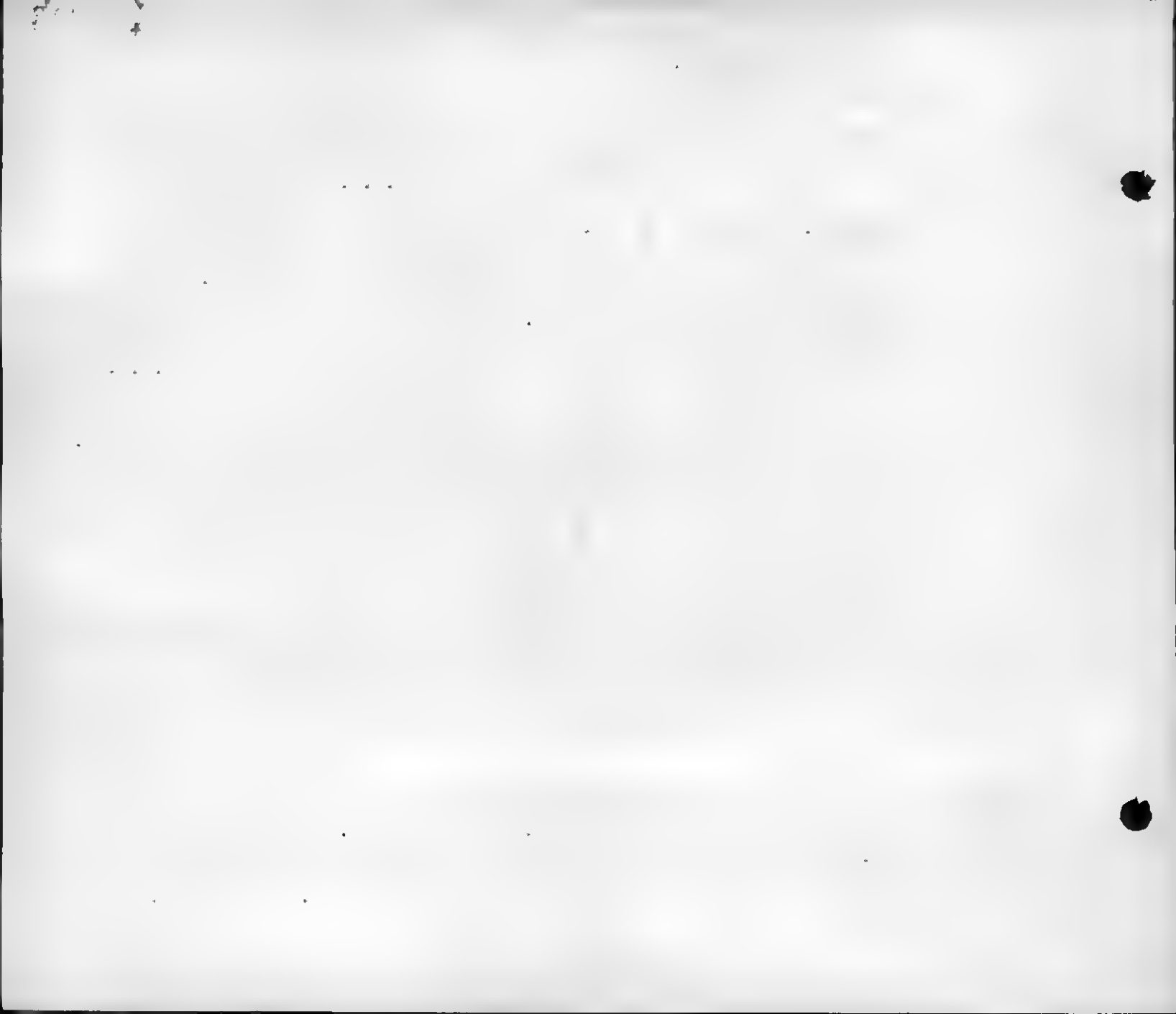
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 10514

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore,</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mt. Wilson</u>	MARYLAND LENGTH OF STAY (in this place) <u>Nov 9 days</u>	STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>R.F.D. #4, Rockville, Maryland</u>	STREET ADDRESS (If rural give location) <u>15X-2</u>
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Morris</u> <u>McComas</u> <u>Gilliss</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>Nov.</u> <u>17</u> <u>19 55</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Feb. 27, 1887</u>
9. AGE last birthday: <u>68</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Electrician</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Blast furnace</u>	
11. BIRTHPLACE (State or foreign country): <u>Travilah, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Scott Gilliss</u>		14. MOTHER'S MAIDEN NAME: <u>Leanah Ricketts</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY NO. <u>278-05-9065A</u>	
17. INFORMANT & ADDRESS: <u>Hospital Records Mt. Wilson, Md.</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>163X</u> IMMEDIATE CAUSE (A) <u>Carcinoma of lung</u> ANTECEDENT CAUSE (B) <u>DUE TO</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>24</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 9</u> , 19 <u>55</u> to <u>Nov. 17</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov. 17</u> , 19 <u>55</u> , and that death occurred at <u>8:50 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>William Newcomer</u>		ADDRESS <u>M.D. Mt. Wilson, Md.</u>	
DATE SIGNED <u>Nov. 17, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/21/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11/21/55</u>		REGISTRAR'S SIGNATURE <u>A. H. Starch</u>	
24. FUNERAL DIRECTOR <u>Wiedefeld</u>		ADDRESS <u>900 E Biddle St</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10515

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No.

I. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Edgemere Md.</u>		<u>10 yrs.</u>		TOWN <u>Edgemere</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 22 Main Ave</u>				STREET ADDRESS (If rural, give location) <u>Box 22 Main Ave</u>			
3. NAME OF DECEASED: (Type or Print) <u>Vincent J. Golczynski</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>November 7, 19 55</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>Married Jan 19 1888</u>		8. DATE OF BIRTH: <u>67</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Stat. Eng. city Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday: <u>67</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>Balto. Md.</u>	
13. FATHER'S NAME: <u>Itanary Golczynski</u>				14. MOTHER'S MAIDEN NAME: <u>Maryanne Duklas</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>Yes</u> (If Yes, give war or dates of service) <u>1</u>				16. SOCIAL SECURITY No.: <u>219-30-8520</u>		17. INFORMANT & ADDRESS: <u>Helen Golczynski Box 22 Main Ave</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<p>4... Immediate cause (a) <u>Coronary artery sclerosis</u> DUE TO</p> <p>Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)</p>							
<p>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</p>							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<p>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</p>							
SIGNATURE <u>R. Fisher</u>		DATE THEREOF <u>Nov. 10 - 55</u>		NAME OF CEMETERY OR CREMATORY <u>Balto. National Cem.</u>		LOCATION (City, town, or county) (State) <u>Frederick Rd Balto. Md.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE REC'D BY LOCAL REG. <u>11/9/55</u>		REGISTRAR'S SIGNATURE <u>A. W. March</u>		FUNERAL DIRECTOR ADDRESS <u>Dingel Bros. 1800 E. Lombard St</u>	



10516 CERTIFICATE OF DEATH

Reg. Dist. No. 45

Item 8, Film G190 12-19-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>md.</u> COUNTY <u>Balto.</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>53 TOWN</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>22 Wendell rd 53</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home</u>				STREET ADDRESS (If rural, give location) <u>7852 Gaston Blvd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Vernon Oliver Grabel</u>				<u>Nov. 18 - 19 55</u>			
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>1923-3-17-1911</u>	9. AGE last birthday: <u>32</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Lutheran</u>	11. BIRTHPLACE (State or foreign country): <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: <u>Oliver Grabel</u>				14. MOTHER'S MAIDEN NAME: <u>Esther Groves</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mary Christine Grabel (Wife)</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
(a) <u>410x</u> Immediate cause DUE TO <u>CORONARY THROMBOSIS</u>						<u>5 minutes</u>	
(b) Antecedent cause(s) DUE TO <u>HYPERTENSION</u>						<u>1 year</u>	
(c) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last DUE TO <u>Mitral Stenosis</u>						<u>2</u>	
11. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:			
21. ACCIDENT SUICIDE HOMICIDE (Specify)				PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Aug 8, 1955</u> , to <u>Nov 18, 1955</u> , that I last saw the deceased alive on <u>Nov 15, 1955</u> , and that death occurred at <u>6:25 P.m.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Monie G. Jacoby</u>				(DEGREE OR TITLE) <u>M.D.</u>		ADDRESS <u>1010 NORTH Point Rd</u> DATE SIGNED <u>11/20/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>11-20-55</u>		NAME OF CEMETERY OR CREMATORY <u>Shippensville Cem.</u>		LOCATION (City, town, or county) (State) <u>Shippensville Pa.</u>	
DATE REC'D BY LOCAL REG. <u>11-18-55</u>		REGISTRAR'S SIGNATURE <u>Edith Hurley</u>		24. FUNERAL DIRECTOR <u>John J. Connelly, Essex, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U.S. DISTRICT

NO. 100

100

10517

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Pennsylvania</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>		LENGTH OF STAY (in this place) <u>one, 1926</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Upton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove Hospital</u>				STREET ADDRESS (If rural give location) <u>Upton</u>			
3. NAME OF DECEASED (Type or Print) <u>Isadore Greenbaum</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 28 19 35</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>W. C.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>1/28/1892</u>	
9. AGE last birthday <u>63</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Taxi</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Joseph Greenbaum</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Kleinberg</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT'S ADDRESS <u>1713 I. St. N.W. Wash. D.C.</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
20. IMMEDIATE CAUSE (A) <u>Cardiac Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>28 days</u>			
21. ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovascular Disease</u>							
22. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetes Mellitus</u>							
23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>11/23/55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carbuncle</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1</u> , 19 <u>53</u> , to <u>Nov. 28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov. 28</u> , 19 <u>55</u> , and that death occurred at <u>11 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Stella Wachler</u>				ADDRESS (Street, city, town, state) <u>M.D. Spring Grove St. Hospital Baltimore Md.</u>		DATE SIGNED <u>11/28/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 30/55</u>		NAME OF CEMETERY OR CREMATORY <u>City Chain</u>		LOCATION (City, town, gr county) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR <u>5</u>		REGISTRAR'S SIGNATURE <u>V.E. Harveys</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Sol. Gerson</u>		ADDRESS <u>1124-26 W. North Ave</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. $\Delta = 0$ 时

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10516

10518

CERTIFICATE OF DEATH

Reg. Dist. No. 114

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>8034 Norm Lane Pkts.</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Norm Lane</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Norm Lane</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>11-21-55</u>		STREET ADDRESS (If rural, give location) <u>8034 Norm Lane Pkts.</u>	
3. NAME OF DECEASED (Type or Print) <u>Frances Elizabeth Huskins</u>		4. DATE OF DEATH (Month) <u>11</u> (Day) <u>18</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Ch</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1878</u> <u>79</u> years
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hom</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Charles Co Md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13. FATHER'S NAME <u>Theodore Bowman</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Slims</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>11-21-55</u>	
17. INFORMANT AND ADDRESS <u>Bessie E. Dawson Aunt</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
260X Immediate cause (a) <u>Pneumo-pneumonia</u>			<u>November 7/55</u>
Antecedent cause(s) (b) <u>Diabetes mellitus</u>			<u>unknown</u>
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>11/18/55</u>		INJURY OCCURRED While at <input checked="" type="checkbox"/> Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 15/55</u> to <u>Nov 18/55</u> , that I last saw the deceased alive on <u>November 15/1955</u> and that death occurred at <u>8 PM</u> from the causes and on the date stated above.			
SIGNATURE <u>J. J. Bowman</u>		ADDRESS <u>117 Remond St Baltimore</u> DATE SIGNED <u>11/18/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>11/22/55</u>	
NAME OF CEMETERY OR CREMATORY <u>West Chester</u>		LOCATION (City, town, or county) <u>Ch</u> (State) <u>MD</u>	
DATE REC'D BY LOCAL REG. <u>11-21-55</u>		REGISTRAR'S SIGNATURE <u>Charles A. Rice</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>6610 W. Barret</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Phys: please write the causes of death clearly and legibly.

VS. A15



10519

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Catonsville</u>	LENGTH OF STAY (in this place) <u>3y. 6 mo 20d.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore #29 3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural give location) <u>903 Wildwood Parkway</u>	
3. NAME OF DECEASED: (First) <u>MARY</u> (Middle) <u>VIRGINIA</u> (Last) <u>HEALY</u>		4. DATE (Month) / (Day) / (Year) OF DEATH: <u>11</u> / <u>8</u> / <u>1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Wid.</u>	8. DATE OF BIRTH: <u>6/18/1884</u>
9. AGE last birthday: <u>71</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>IRA LA FEVER ZIMMERMAN</u>		14. MOTHER'S MAIDEN NAME: <u>MARIAN HURLEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>unk.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unk.</u>	
17. INFORMANT & ADDRESS: <u>This Hospital's Records</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>450.0</u>			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			
(A) <u>MALNUTRITION</u>			
DUE TO			
(B) <u>DEHYDRATION</u>			
DUE TO			
(C) <u>SENILE BRAIN Disease</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>GENERALIZED-ARTERIO-SCLEROSIS</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>4/19</u> , 1952 to <u>11/8</u> , 1955, that I last saw the deceased alive on <u>11/7</u> , 1955, and that death occurred at <u>6:40</u> A.M. from the causes and on the date stated above.			
SIGNATURE <u>Bruno Radauskas</u>		ADDRESS <u>Spring Grove St. Hosp.</u> DATE SIGNED <u>11/8/1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 11. 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11/8/55</u>		REGISTRAR'S SIGNATURE <u>A.W. Hedrick</u>	
24. FUNERAL DIRECTOR <u>HENRY SANDER & SONS, INC.</u>		ADDRESS <u>Baltimore Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

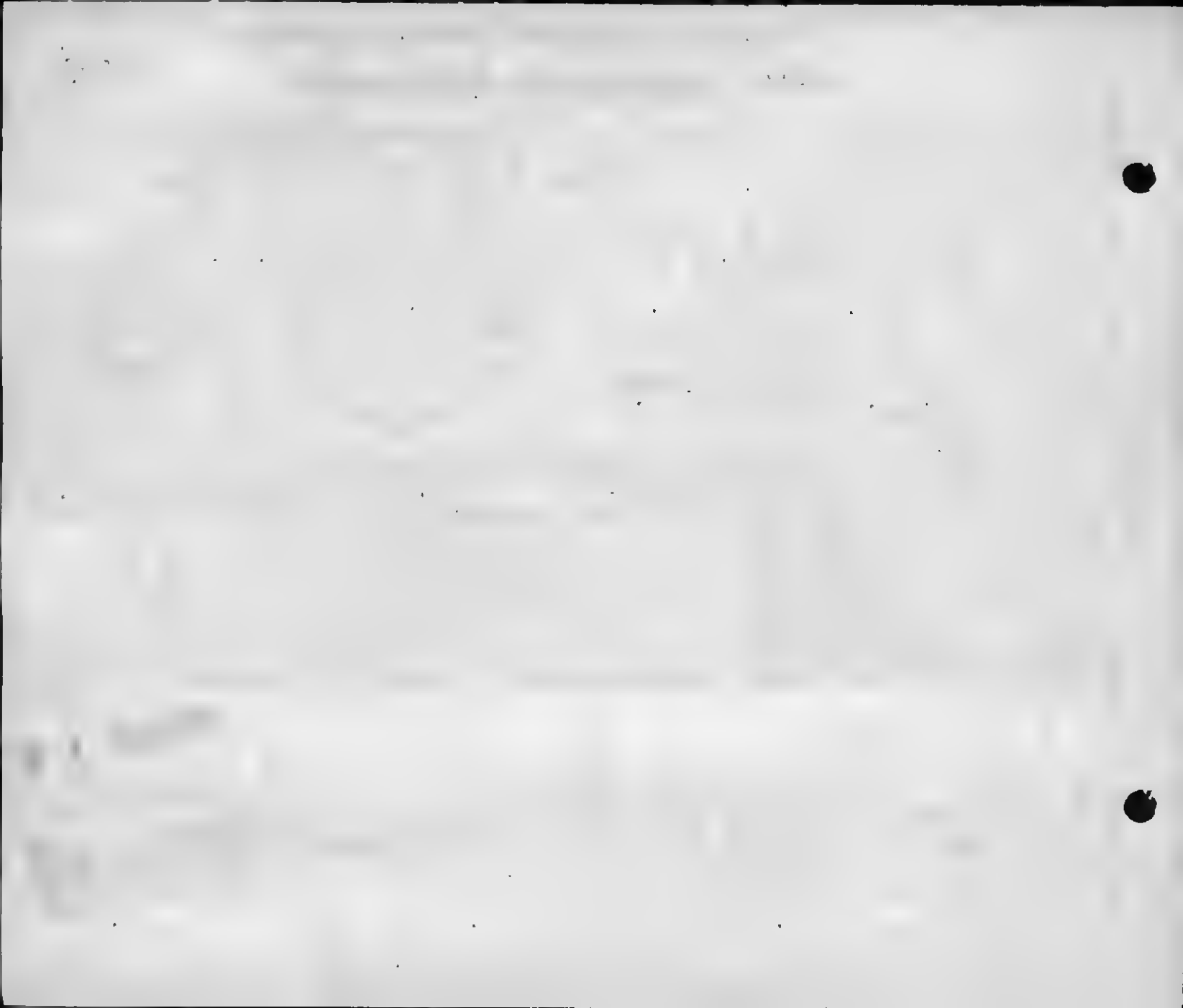
10520

CERTIFICATE OF DEATH

10518

Reg. Dist. No. 45

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baylight Beach</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baylight Beach</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Chesapeake Rd. Rt 10 Box 90</u>				STREET ADDRESS (If rural give location) <u>Chesapeake Rd. Rt. 10 Box 90</u>			
3. NAME OF DECEASED (Type or Print) <u>Mr. Frank B. Hedrick, Sr.</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>November 22nd 1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>July 7, 1892</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oilier, Bethlehem Steel Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-07-7899</u>		17. INFORMANT & ADDRESS <u>Chesapeake Road</u> <u>Mrs. Bernice Hedrick, Rt 10 Box 90.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>acute Coronary Insufficiency</u>						INTERVAL BETWEEN ONSET AND DEATH <u>20 min.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Artery Disease</u>						<u>2 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 1952</u>, to <u>Nov 22</u>, 19<u>55</u>, that I last saw the deceased alive on <u>Nov 22</u>, 19<u>55</u>, and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James F. Means</u>		DATE THEREOF <u>Nov. 25, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Park</u>		LOCATION (City, town, or county) (State) <u>Elkridge, Balto Co. Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>Mrs. Edith Hurley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck, 5305 Harford Road #14</u>		DATE SIGNED <u>11-22-55</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6
1955

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Essex</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Essex</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sewer Road</u>				STREET ADDRESS (If rural, give location) <u>Unknown</u>			
3. NAME OF DECEASED: (Type or Print) <u>Baby Boy</u>		(First) (Middle) (Last) <u>LEITCHON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>11 7 19 55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday: yrs. <u>11</u> months <u>11</u> days	IF UNDER 1 YEAR IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a)..... <u>Postpartum Negligence</u> DUE TO Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c).....							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) <u>Room Street</u>		21c. (City or town) <u>Baltimore</u>		21d. (County) <u>Baltimore</u> (State) <u>Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>11 7 55 M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Undetermined</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .							
SIGNATURE <u>Paul F. Green</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11/7/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Cremated</u>		DATE THEREOF <u>11 28 55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <u>11/16</u>		REGISTRAR'S SIGNATURE <u>R. H. [Signature]</u>		24. FUNERAL DIRECTOR		ADDRESS	

DEPT. OF WAR

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REC-1

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10521 CERTIFICATE OF DEATH

10519

304

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		STATE <u>Md</u>		COUNTY <u>BALTO.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>CATONSVILLE</u>		<u>17 months</u>		TOWN <u>BALTIMORE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>14 SPRING GROVE ST. HOSP.</u>				<u>7 L. AILERON DRIVE</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>MARY HETTERMAN</u>				<u>11 19 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F</u>	<u>W</u>	<u>DIVOR.</u>	<u>Unknown</u>	<u>72</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>housewife</u>				<u>—</u>		<u>PENNSYLVANIA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>—</u>				<u>—</u>		<u>Hospital Records</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
475X IMMEDIATE CAUSE (A) <u>Heart Failure</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Pneumonia</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<u>—</u>		<u>—</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County)	(State)
<input type="checkbox"/>		<u>—</u>		<u>—</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>—</u>		<u>—</u>		<u>—</u>			
22. I hereby certify that I attended the deceased from <u>July 10, 1954</u> , to <u>Nov 19, 1955</u> , that I last saw the deceased alive on <u>Nov 19, 1955</u> , and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Shirley Williams</u>				ADDRESS (Street, city, town, state) <u>M.D. Spring Grove State Hospital Catonsville</u>			
DATE <u>11-23-55</u>				DATE SIGNED <u>11-19-55</u>			
23. BURIAL, CREATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>burial</u>		<u>11-23-55</u>		<u>Proctor's Cemetery</u>		<u>Harmon's Rural Ave.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>—</u>		<u>J. E. Hetter</u>		<u>—</u>		<u>—</u>	
DATE <u>11-23-55</u>		<u>V. E. Harvey</u>		<u>—</u>		<u>—</u>	



10522

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL, OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<u>Overlea</u>	<u>2 mo.</u>	<u>Overlea</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>2 E. Maple Ave</u>		<u>2 E. Maple Ave</u>	
3. NAME OF DECEASED. (Type or Print)		4. DATE (Month) (Day) (Year)	
<u>Arthur Lee Hichew</u>		<u>Nov. 23 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE. MARRIED. WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Feb 3 1891</u>
9. AGE last birthday		10. BIRTHPLACE (State or foreign country):	
<u>64</u> yrs.		<u>Balto.</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Balto.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Samuel Hichew</u>		<u>Irene Frazier</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>Yes</u>		<u>None</u>	
17. INFORMANT & ADDRESS:			
<u>Elsie M. Hichew 2 E. Maple Ave</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A)			
<u>Carcinoma Pancreas</u>			<u>6 months</u>
ANTECEDENT CAUSE (B)			
<u>with metastases to Liver</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work			
22. I hereby certify that I attended the deceased from <u>9/2/55</u> to <u>11/22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/22</u> , 19 <u>55</u> , and that death occurred at <u>4:15</u> A.M., from the causes and on the date stated above.			
SIGNATURE <u>Joseph H. Zierler</u>		DATE SIGNED <u>11/23/55</u>	
M. D. <u>2318 E. Edgar Place</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>MD</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>11-23-55</u>		<u>W. H. H. H. H.</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Dyppel Bros</u>		<u>7110 BELAIR RD 6</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



10523

10521
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Pat.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
<input checked="" type="checkbox"/> TOWN <u>White Hall</u>		TOWN <u>White Hall</u>	<input checked="" type="checkbox"/>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wilson Rd.</u>		STREET ADDRESS (If rural, give location)	<u>Wilson Rd.</u>
3. NAME OF DECEASED:		4. DATE OF DEATH	
(Type or Print)	(First) (Middle) (Last)	(Month) (Day) (Year)	
<u>Jesse</u>	<u>Cleveland</u>	<u>Nov. 28</u>	<u>1955</u>
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED.	8. DATE OF BIRTH:
<u>male</u>	<u>white</u>	<u>married</u>	<u>Dec. 30, 1884</u>
9. AGE last birthday: <u>70</u> yrs.		10. MONTHS <u>28</u> Days <u>19</u> Hours <u>55</u> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Rtd Dispatcher Gulf Oil Co.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Jesse F. Hobson</u>		<u>Lucy Scott</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:	
<u>no</u> (If Yes, give war or dates of service)			
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
<u>Mrs. Bertha L. Hobson-Wilson Rd., White Hall</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
<u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) <u>giving rise to the above cause</u> Diseases or conditions, if any, stating underlying cause last (c) <u>stating underlying cause last</u> DUE TO		
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY?	
				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, street, office bldg., etc., INJURY)	21c. (City or town)	(County)	(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE E. M. France CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 11/28/55
 M. D. DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>12/1/55</u>	<u>Woodlawn Cem.</u>	<u>Woodlawn, Md.</u>	
DATE REGD BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>11/30/55</u>	<u>W. H. Hestrich</u>	<u>Thos. J. Hestrich & Sons - Baltimore</u>	<u>17th.</u>	

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

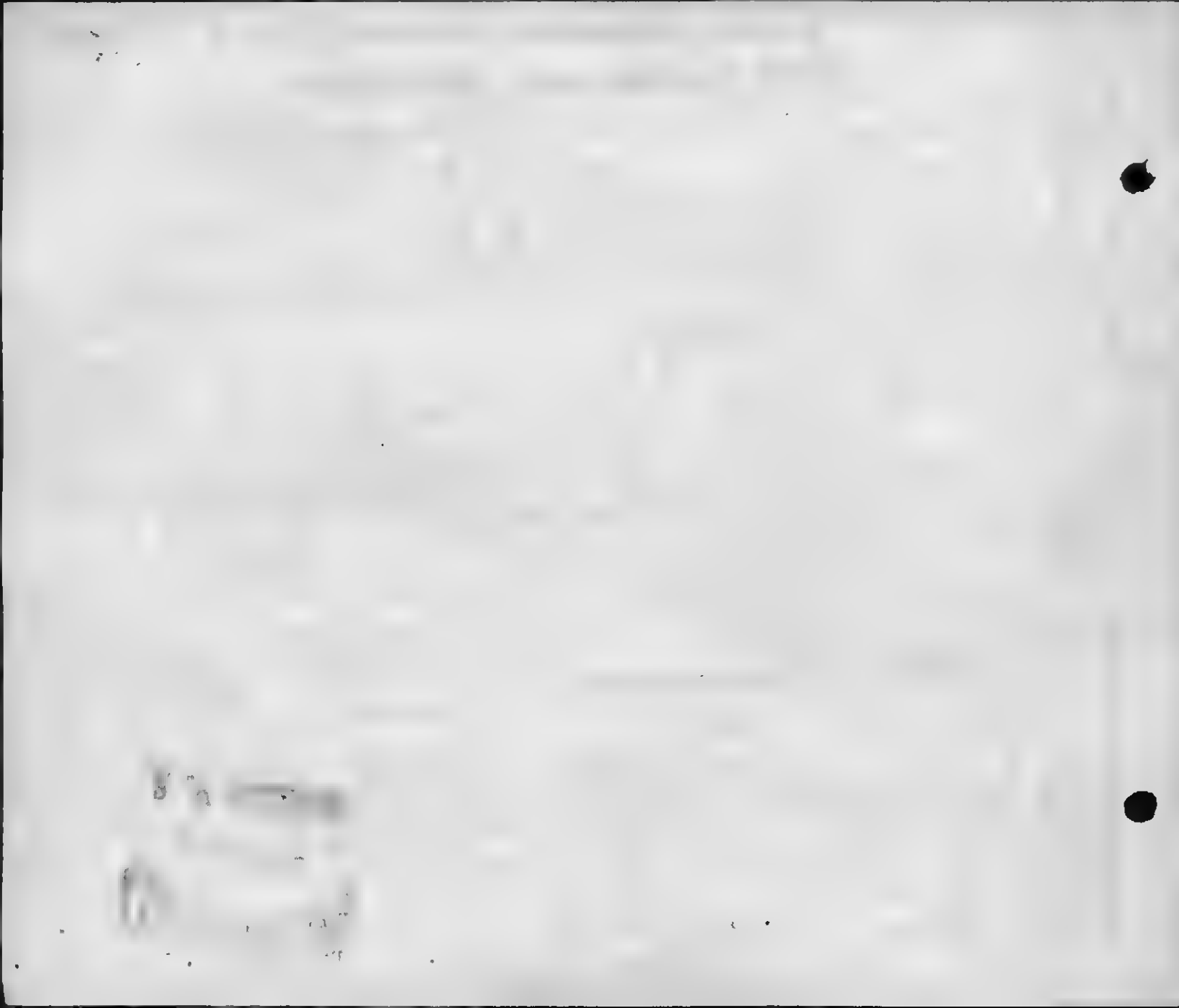
10522

10524

CERTIFICATE OF DEATH

Reg. Dist. No. 83

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>M.D.</u>		COUNTY <u>ST. MARYS</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>GLYNDON</u>		<u>14 Mo.</u>		TOWN <u>LEONARDTOWN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Worthington Road (Melinda)</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JOSEPH</u> (Middle) <u>HOPKINS</u> (Last)				(Month) <u>NOVEMBER</u> (Day) <u>30</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>MALE</u>	<u>WHITE</u>	<u>SINGLE</u>	<u>MAY 8, 1870</u>	<u>85</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>HOUSE SERVANT</u>				<u>MARYLAND</u>		<u>U. S.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		<u>NONE</u>		<u>MRS. ALBERT ZIMMERMAN, GLYNDON, M.D.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>PULMONARY EDEMA</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROTIC C.V. DISEASE</u>				<u>14 MOS.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>WITH CARDIAC DECOMPENSATION</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>SEPT.</u> , 1954, to <u>NOV. 30</u> , 1955, that I last saw the deceased alive on <u>NOV. 28</u> , 1955, and that death occurred at <u>11:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Martin E. Stwood</u>				ADDRESS (Street, city, town, state) <u>M.D. 48 MAIN ST. REISTERSTOWN MD</u> DATE SIGNED <u>11/30/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec. 3, 1955</u>		<u>Lorraine</u>		<u>Woodlawn, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>Mary Elene</u>		<u>John O. Mitchell & Sons Inc.</u>		<u>1900 Eutaw Pl.</u>	
DATE							



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10525

CERTIFICATE OF DEATH

105234

Reg. Dist. No. #5

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY 1	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Fort Howard, Md.		34 days		TOWN Essex		-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital				STREET ADDRESS (If rural give location)			
50 344 Townsend Road				1			
3. NAME OF DECEASED (Type or Print)			(First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)	
RALPH D. HOYE						November 12 1955	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Married	3/28/10	45 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Guard		Radio Corp.		Murray City, Ohio		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
James Hoyer				Mary Wolfe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
Yes WW II		274-10-3734		Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
I 116x IMMEDIATE CAUSE (A) EWING SARCOMA WITH METASTASIS						11 Months	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
1 Oct. 11, 1955		Abscess left ischio anal space		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
M.							
22. I hereby certify that I attended the deceased from Oct. 9, 1955, to Nov. 12, 1955, that I last saw the deceased on Nov. 12, 1955, and that death occurred at 11:10 PM, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
HOWARD C. KRAMER				VAH, Fort Howard, Md.		11/13/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		11-16-55		Oaklawn Cemetery		Baltimore, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 11/14/55		Edith Stanley		Bruzdzinski Funeral Home		1407 Eastern Ave. Baltimore, Md.	
		Dawson L. Finkels					

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10526 CERTIFICATE OF DEATH

10524

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO. CO</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>CATONSVILLE</u>		<u>5 WK</u>		TOWN <u>CATONSVILLE 28</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5921 CHARNWOOD RD</u>				STREET ADDRESS (If rural give location) <u>5921 CHARNWOOD RD</u>			
3. NAME OF DECEASED (Type or Print) <u>OLLIE OVIDA HUFFMAN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>11/29/55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>MAR. 3, 1883</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pa.</u>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>HARMON HEPLER</u>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Harmon W. Huffman</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
42201 IMMEDIATE CAUSE (A) <u>Acute Cardiac Failure</u>				<u>1 day</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>A. S. C. V Disease</u>				<u>1 year</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 23, 1955</u> to <u>Nov 29, 1955</u> , that I last saw the deceased alive on <u>Nov 29, 1955</u> , and that death occurred at <u>10:45 AM</u> , from the causes end on the date stated above.							
SIGNATURE <u>James Stowell</u> M.D.				ADDRESS (Street, city, town, state) <u>Catonville</u>		DATE SIGNED <u>11-29</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12/2/55</u>		NAME OF CEMETERY OR CREMATORY <u>Family Plot</u>		LOCATION (City, town, or county) (State) <u>NEW BETHELHEM, PA.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>McDubb + Son</u>		ADDRESS <u>28</u>	
DATE <u>11/30/55</u>							

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 180525
10465 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Halethorpe</u>	MARYLAND LENGTH OF STAY (in this place) <u>50 yrs</u>	STATE <u>Md</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Halethorpe</u> 51	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>825 Selma ave</u>		STREET ADDRESS (If rural give location) <u>1825 Selma ave</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Loisne Shelton Hull</u>		4. DATE OF DEATH: <u>Nov 13 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Feb 10-1881</u> 74 yrs
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Lawyer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Private, retired</u>	11. BIRTHPLACE (State or foreign country): <u>Baltimore City</u>
13. FATHER'S NAME: <u>Charles W. Hull</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Ann Garden</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Mrs Ann King daughter, Halethorpe Md</u>	
16. SOCIAL SECURITY NO. <u>none</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE (A) <u>Acute coronary occlusion</u>			2 hr
ANTECEDENT CAUSE (B) <u>Chronic coronary</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>General arteriosclerosis</u>			5-10 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Aug 1955</u> , to <u>Nov 13 1955</u> , that I last saw the deceased alive on <u>Nov 12, 1955</u> , and that death occurred at <u>8:30</u> M., from the causes and on the date stated above.			
SIGNATURE <u>DR. B. B. B. B.</u>		DATE SIGNED <u>Nov 13 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		NAME OF CEMETERY OR CREMATORY <u>London Park</u>	
DATE THEREOF <u>Nov 16-55</u>		LOCATION (City, town, or county) <u>Baltimore</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11-15-55</u>		24. FUNERAL DIRECTOR <u>Adm. H. H. H. H.</u>	
REGISTRAR'S SIGNATURE <u>Adm. H. H. H. H.</u>		ADDRESS <u>1825 Selma Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10527 CERTIFICATE OF DEATH

Items 1,2: film G189 12-1-55 L

Reg. Dist. No.

10526
38

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
55 TOWN Towson				TOWN Towson			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS		(If rural give location)	
61 Dunkirk Road				61 Dunkirk Road			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
Mr. Raymond D. Hull				Nov. 24th 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
male	white	married	March 10, 1900	55 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Manager Dept. Store				Baltimore, Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Mr. John Hull				?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)				Mrs. Mildred K. Hull, 611 Dunkirk Rd.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
453.3 IMMEDIATE CAUSE (A)				Coronary Occlusion			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				peripheral vascular disease			
STATING UNDERLYING CAUSE LAST. DUE TO (C)				(evening 4)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				1 hr.			
				3.4 hr.			
				40?			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Apr. 19 55, to Nov 24, 19 55, that I last saw the deceased alive on Nov 11, 19 55, and that death occurred at 2:30 A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
Leonard J. Ruck				M.D. 4th St. Baltimore, Md.		11/25/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial		Nov. 28, 1955		Parkwood Cemetery		Baltimore, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE		Mabel Gray		Leonard J. Ruck, 5305 Harford Road #14			

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10528 CERTIFICATE OF DEATH

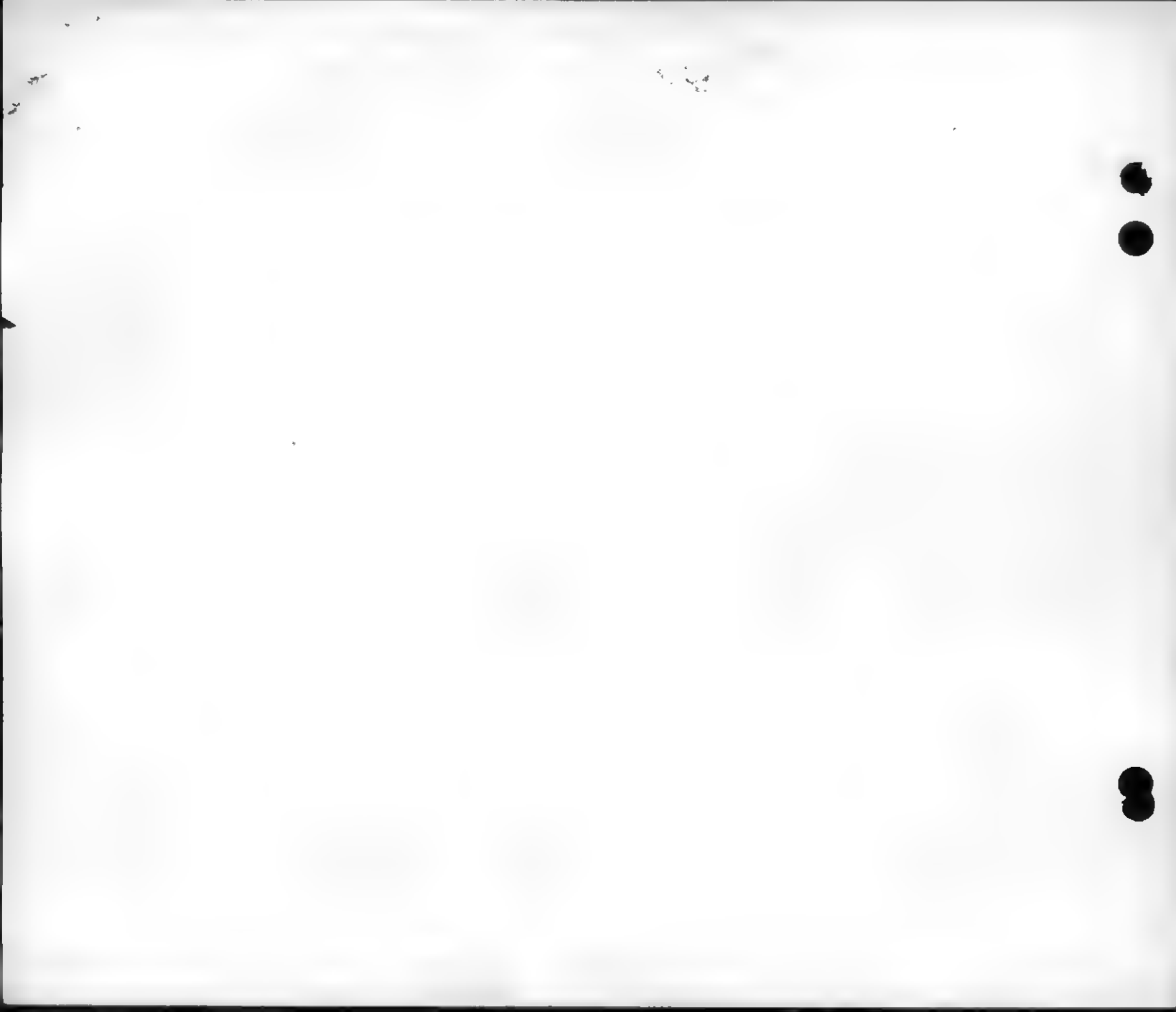
Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fullerton</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fullerton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 17, E. Joppa Road</u>				STREET ADDRESS (If rural give location) <u>Box 17, E. Joppa Road</u>			
3. NAME OF DECEASED: (First) <u>J.</u> (Middle) <u>DALE</u> (Last) <u>HUMMEL</u>		4. DATE OF DEATH: (Month) <u>Nov.</u> (Day) <u>30</u> (Year) <u>1955</u>					
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Feb. 17, 1900</u>	9. AGE last birthday: <u>55</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION: Give kind of work done during most of working life, even if retired: <u>Hostler</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Stables</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John F. Hummel</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Swain</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS: <u>Chas. R. Hummel 3642 Lyndale Ave.</u>			
18. MEDICAL CERTIFICATION							Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>162X</u> Immediate cause (a) <u>Bronchial obstruction</u> DUE TO Antecedent causes (s) (b) <u>Pulmonary abscess</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (c) <u>Bronchogenic Carcinoma</u>							<u>3 days</u> <u>2 yrs.</u> <u>undet.</u>
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death. <u>Endogenous malnutrition due to carcinoma</u>							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY ?
							Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, or office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 1955</u> , to <u>Nov 30, 1955</u> , that I last saw the deceased alive on <u>11-29, 1955</u> , and that death occurred at <u>7:15 am</u> , from the causes and on the date stated above.							
SIGNATURE <u>John C. Hyerme</u>		(Degree or title)		ADDRESS <u>7527 Belair Rd Baltimore</u>		DATE SIGNED <u>12-1-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Dec. 3, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Zion Evan. Lutheran</u>		LOCATION (City, town, or county) (State) <u>Stemmers Run, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR <u>Ullrich Funeral Home 4210 Belair Road.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



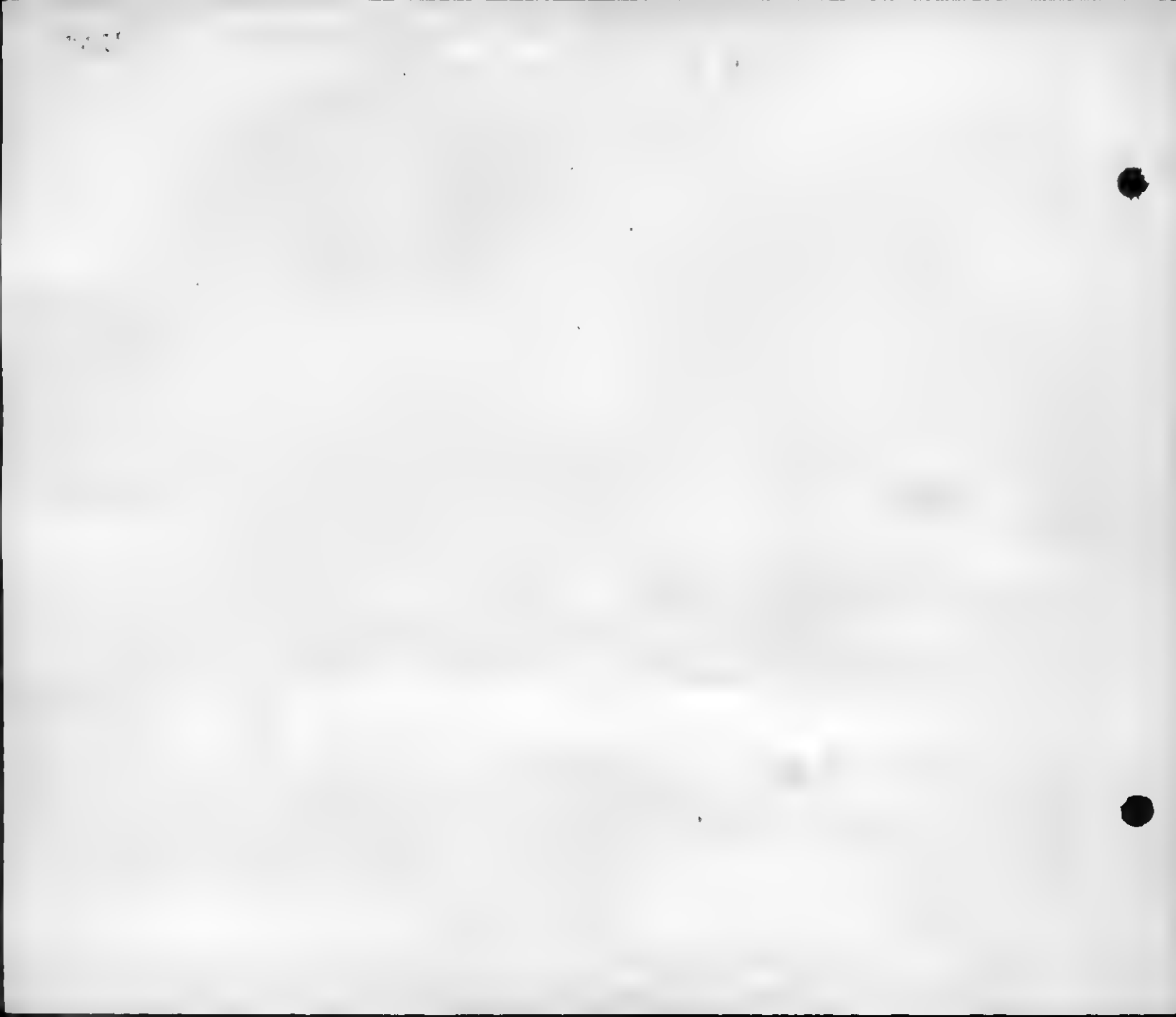
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>OW</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>133 Dumbarton Rd.</u>				STREET ADDRESS (If rural give location) <u>133 Dumbarton Rd. Zone 12</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>HENRY</u> <u>BARRAUD</u> <u>HUNT</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Nov.</u> <u>24</u> <u>19 55</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>June 27, 1895</u>	9. AGE last birthday <u>60</u> yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>salesman</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>tools</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>	
13. FATHER'S NAME: <u>Rev. Henry Hunt</u>				14. MOTHER'S MAIDEN NAME: <u>Ida Tankard</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mrs. Fannie C. Hunt-133 Dumbarton Rd.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Anterior-Septal Heart Disease</u>						<u>2 yrs.</u>	
ANTECEDENT CAUSE (B) <u>Chronic Bronchiectasis</u>						<u>5 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>None</u>				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb. 3</u> , 19 <u>50</u> , to <u>Nov. 24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov. 12</u> , 19 <u>55</u> , and that death occurred at <u>4:45</u> M., from the causes and on the date stated above.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>				DATE THEREOF <u>11/26/55</u>		NAME OF CEMETERY OR CREMATORY <u>Franktown</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11-23</u>				REGISTRAR'S SIGNATURE <u>L</u>		FUNERAL DIRECTOR <u>Wm. J. Lickner & Sons - Balto</u>	
				ADDRESS		ADDRESS <u>17 Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Rural Pikesville</u>	LENGTH OF STAY (in this place) <u>Lifetime</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Pikesville</u>	<u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>503 Sudbrook Road</u>		STREET ADDRESS (If rural give location) <u>503 Sudbrook Road</u>	

3. NAME OF DECEASED: (Type or Print) <u>Margaret L. Irish</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Nov. 20 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>May 10, 1912</u>
9. AGE last birthday: <u>43</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13. FATHER'S NAME: <u>Henery Parker</u>	14. MOTHER'S MAIDEN NAME: <u>Edith Bottermmer</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>	16. SOCIAL SECURITY NO. <u>no</u>
17. INFORMANT & ADDRESS: <u>Pikesville Herschel R. Irish, 503 Sudbrook Road</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>		<u>15 min.</u>
ANTECEDENT CAUSE (B) <u>Angina Pectoris</u>		<u>18 mos.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Hypertension</u>		<u>15 years.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JAN. 1942 to Nov. 20, 1955, that I last saw the deceased alive on Oct. 21, 1955, and that death occurred at 10 A.M. from the causes and on the date stated above.

SIGNATURE <u>James R. Miller</u>	ADDRESS <u>Pikesville - Md</u>	DATE SIGNED <u>11/22/55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>Nov. 23, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>
LOCATION (City, town, or county) <u>Woodlawn, Maryland</u>		
DATE REC'D BY LOCAL REGISTRAR <u>Nov. 23, 1955</u>	REGISTRAR'S SIGNATURE <u>Barth A. Newell</u>	24. FUNERAL DIRECTOR'S ADDRESS <u>Frank H. Newell, Pikesville</u>

MARGIN RESERVED FOR BINDING

S. A.

10529

MARYLAND STATE DEPARTMENT OF HEALTH
10531 CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY BALTIMORE		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MD. COUNTY BALTIMORE	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TIMONIK		CITY (If outside corporate limits, write RURAL and give nearest town) TIMONIK	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 38 DAKWAY		STREET ADDRESS (If rural, give location) 38 DAKWAY	
3. NAME OF DECEASED (Type or Print) EDWIN (First) W. (Middle) ISAACS (Last)		4. DATE OF DEATH (Month) 11 (Day) 7 (Year) 1955	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH 11-7-37
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN		10b. KIND OF BUSINESS OR INDUSTRY FOOT.	9. AGE last birthday 38 yrs. If under 1 year Months Days If under 24 hours Hours Mins.
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Irvin Melville Isaacs		14. MOTHER'S MAIDEN NAME Clara	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) W.W. II		16. SOCIAL SECURITY No. 21-070 1617	
17. INFORMANT AND ADDRESS Family			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) 22 CALIBRE RIFLE WOUND THROUGH HEART		INSTANTLY
Antecedent cause(s) (b) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
19. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death) PSYCHOSIS		

19a. DATE OF OPERATION 11-7-55	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, and that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☒ homicide ☐ undetermined ☐

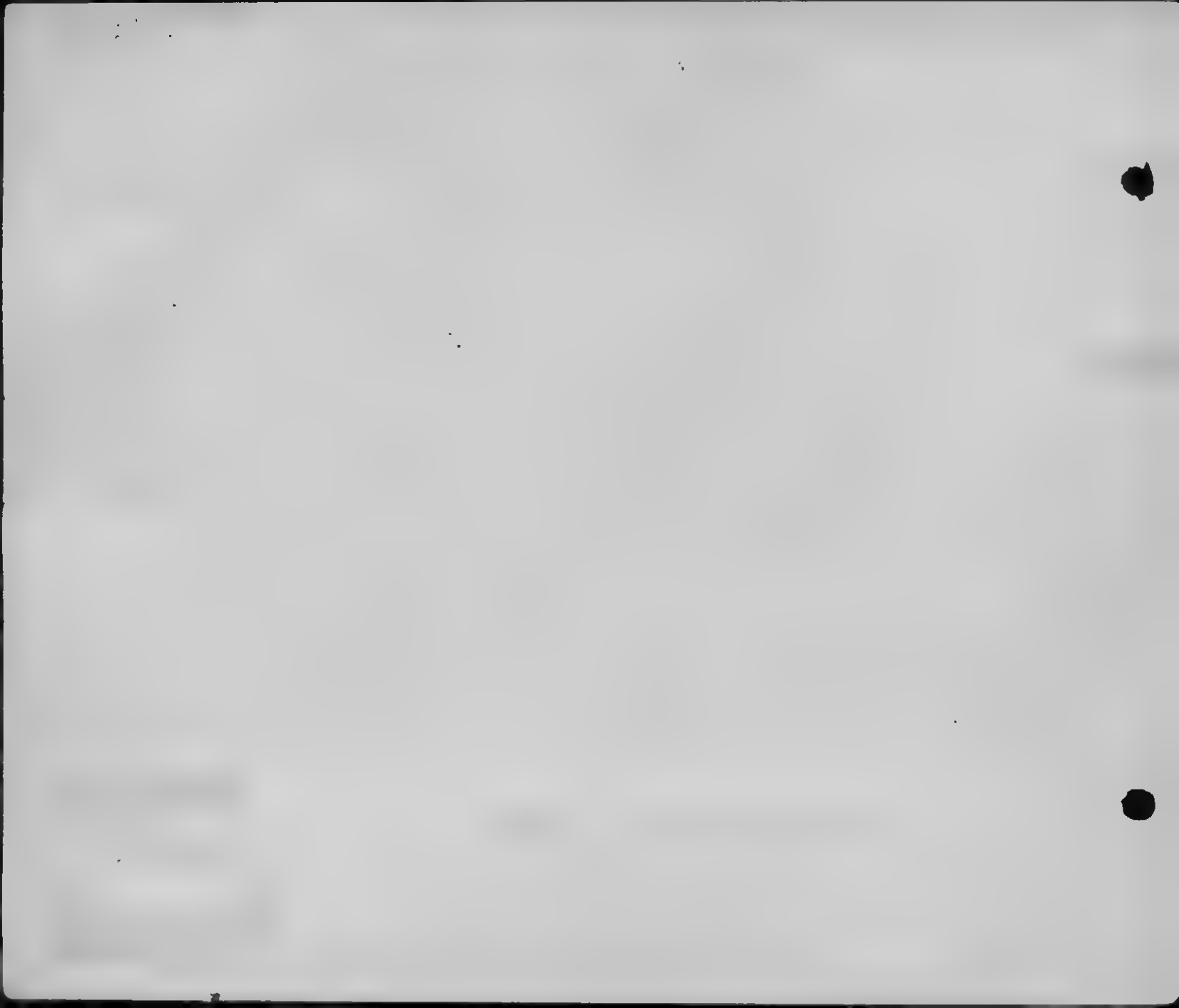
SIGNATURE **William A. Parsbury** (Degree or title) **M.D.** ADDRESS **Timonium** DATE SIGNED **11/7/55**

RIAL CREMATION (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
NO	Nov. 10, 1955	St. Mary's	Baltimore

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE **Nov. 10, 1955** **Mabel C. Gray** ADDRESS **John Burns, Son**

MARGIN RESERVED FOR INDEXING

USE WRITING FLUENTLY, WITH UNFADING INK. Supply every item of information carefully. The correct use is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH
10532 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

10530

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. US. AL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Fort Howard		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Sparrows Point	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Fort Howard Hospital		STREET ADDRESS Box 258 D, Route 10, --19	
3. NAME OF DECEASED (First) LAURENCE (Middle) J. (Last) JACKSON		4. DATE OF DEATH (Month) Nov. (Day) 7 (Year) 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, WIDOWED (Specify)	8. DATE OF BIRTH June 20, 1891
9. AGE last birthday 64 yrs.		10. If under 1 year: Months 10 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Layer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Mc H. Jackson		14. MOTHER'S MAIDEN NAME Agnes Barker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS Mrs. Catherine Jackson Box 258 D, Route 10			

18. MEDICAL CERTIFICATION		
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 4201 Immediate cause (a) Coronary Occlusion Antecedent cause(s) (b) Arteriosclerotic H.D. Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		INTERVAL BETWEEN ONSET AND DEATH 10 hrs 1 hr.
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection ☒, Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident, suicide, homicide, undetermined.

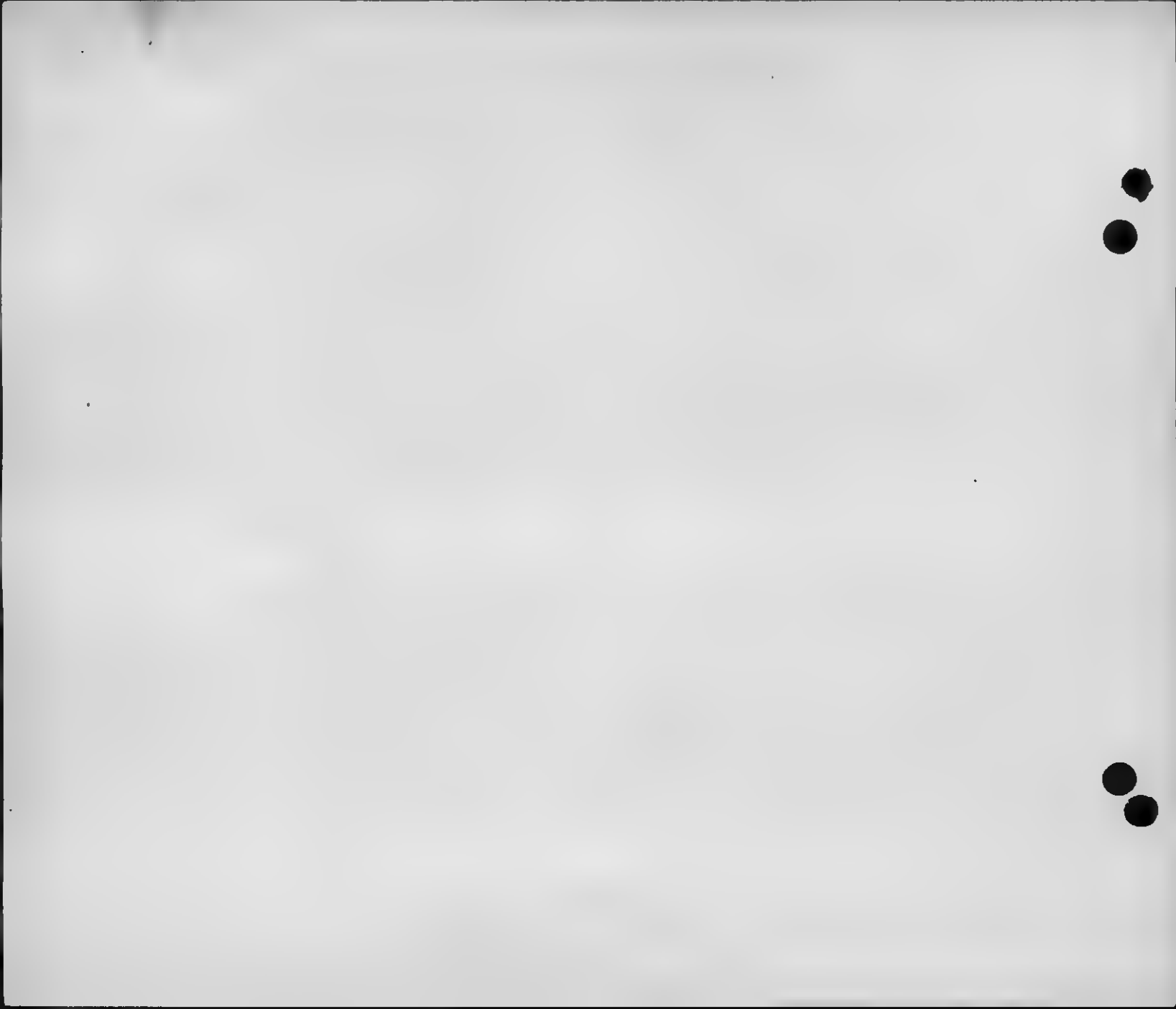
SIGNATURE **Jack C. Collins, M.D. Deputy Medical Examiner** ADDRESS **Balt 22** DATE SIGNED **11-8-55**

23. BURIAL, CREMATION OR OTHER FINAL DISPOSITION (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov. 10, 1955	Baltimore National	Baltimore, Md.
DATE REC'D BY LOCAL REG. 11/9/55	REGISTRAR'S SIGNATURE A. J. Henschel	24. FUNERAL DIRECTOR	ADDRESS
		Ullrich Funeral Home	2112 Dundalk Ave.

MARGAN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct entry is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A



10533

CERTIFICATE OF DEATH

Items 8,9: Film G189 11-22-55L

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY BALTIMORE MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) WHITE HALL LENGTH OF STAY (in this place) 16 yrs.
 OR TOWN WHITE HALL
 HOSPITAL OR INSTITUTION OR STREET ADDRESS WHITE HALL P.O. BALTO. CO. MD.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY BALTO
 CITY (If outside corporate limits, write RURAL and give nearest town) WHITE HALL
 OR TOWN WHITE HALL
 STREET ADDRESS (If rural give location) WHITE HALL P.O.

3. NAME OF DECEASED:

(First) MARIAN (Middle) ASHBURY (Last) JESSOP
 (Type or Print)

4. DATE OF DEATH: (Month) NOV. (Day) 9 (Year) 1955

5. SEX:

FEMALE

6. COLOR OR RACE:

WHITE7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED

8. DATE OF BIRTH: 1872
JULY 31, 1872

9. AGE last birthday: 83 yrs. 814 Months 814 Days 814 Hours 814 Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): BALTO. MD.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME:

JOSEPH M. ASHBURY

14. MOTHER'S MAIDEN NAME:

EMMA B. ELMER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: MRS. FRANK J. FOX - WHITE HALL MD.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1

Immediate cause

(a) Cardio-Vascular disease
 DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
 OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1950, to 11/9, 1955, that I last saw the deceased

alive on 11/8, 1955, and that death occurred at 6:20 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

DATE THEREOF

11-11-1955

NAME OF CEMETERY OR CREMATORY

CHESTNUT GROVE PRES. CHURCH

LOCATION (City, town, or county)

SWEET AIR - BALTO. CO. MD.

(State)

DATE REC'D BY LOCAL REGISTRAR

11/10/55

REGISTRAR'S SIGNATURE

A. J. Hensch

24. FUNERAL DIRECTOR

Wm. H. Hensch

ADDRESS

4905 York Rd.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. Also this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10534

CERTIFICATE OF DEATH

10532

Reg. Dist. No.

38

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL or end give nearest town) <u>Towson</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8523 Chestnut Oak Road</u>				STREET ADDRESS (If rural give location) <u>8523 Chestnut Oak Road #4</u>			
3. NAME OF DECEASED (Type or Print) <u>Mrs. Gladys A. Kaelin</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>November 1 19 55</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>May 10, 1910</u>		9. AGE last birthday <u>45</u> yrs.	10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Adam Alt</u>				14. MOTHER'S MAIDEN NAME <u>Ida E. Shreve</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr. Richard E. Kaelin, 8523 Chestnut Oak</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Cerebrovascular hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 am 11/1</u>			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>U</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/15</u> , 19 <u>52</u> , to <u>11/1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/1</u> , 19 <u>55</u> , and that death occurred at <u>5A</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Richard E. Kaelin</u>				ADDRESS (Street, city, town, state) <u>M.D. 8523 Chestnut Oak Road #4</u>		DATE SIGNED <u>11/1/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 5, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. READ BY REGISTRAR <u>Nov. 2, 1955</u>		REGISTRAR'S SIGNATURE <u>Michael Gray</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10533
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 45

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>Essex 21</u>		TOWN <u>Essex 21</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>395 Thompson Blvd.</u>		STREET ADDRESS (If rural, give location) <u>395 Thompson Blvd.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(Type or Print)	(First) (Middle) (Last)	(Month) (Day) (Year)	
<u>Charles O Keenan</u>		<u>Nov 11 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Male</u>	<u>White</u>	<u>widowed</u>	<u>July 31-1901</u>
9. AGE last birthday:		10. IF UNDER 1 YEAR	
<u>54</u> yrs.		Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>U.S.A.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Charles O Keenan</u>		<u>May Barnes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:	
<u>No</u>		<u>234-18-6607</u>	
17. INFORMANT & ADDRESS:			
<u>W. Hooten 1305 Huntington Ave</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
42. Immediate cause (a)..... <u>Coronary Occlusion</u>			<u>10 minutes</u>
Antecedent cause(s) (b)..... <u>Arteriosclerosis H.D.</u>			<u>1 year</u>
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c).....			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at Not while at work <input type="checkbox"/> <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Jack E Collins</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11-12-55</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>11/14/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Huntington Md 21</u>	
DATE REC'D BY LOCAL REG. <u>11/12/55</u>		REGISTERAR'S SIGNATURE <u>Garth Shirley</u>	
24. FUNERAL DIRECTOR <u>James J. Muzynski</u>		ADDRESS <u>1407 Eastern Ave</u>	

10-10-10

10-10-10



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10536 CERTIFICATE OF DEATH

Reg. Dist. No.

10534

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Id.</u>	COUNTY <u>Baltimore</u>
CITY (if outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (if outside corporate limits, write RURAL and give nearest town)	
<u>Woodlawn</u>	<u>Life</u>	<u>Woodlawn</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9 Beacon Hill Rd.</u>		STREET ADDRESS (If rural give location) <u>9 Beacon Hill Rd.</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Harry</u>	(Middle) <u>Aloysius</u>	(Last) <u>Kelly, Sr.</u>	
5. SEX: <u>Male</u>		6. DATE OF BIRTH: <u>Dec. 1, 1890</u>	
7. COLOR OR RACE: <u>White</u>	8. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	9. AGE last birthday <u>64</u> yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Marine Engineer</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Baltimore, Id.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Harry A. Kelly</u>		14. MOTHER'S MAIDEN NAME: <u>Lary E. Mitchell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-07-5087</u>	
17. INFORMANT & ADDRESS: <u>Dorothy F. Severin - 9 Beacon Hill Rd.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>		<u>30 minutes</u>	
ANTECEDENT CAUSE (B) <u>Carcinoma of Head of the Pancreas</u>		<u>4 months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>Sept. 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Head of the pancreas (Johns Hopkins Hospital)</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. HOW DID INJURY OCCUR?	
21G. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>Nov. 14, 1955</u> , to <u>Nov. 26, 1955</u> , that I last saw the deceased alive on <u>Nov. 21, 1955</u> , and that death occurred at <u>3:15 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>William T. Trabant</u>		DATE SIGNED <u>11/28/55</u>	
ADDRESS <u>M.D. 5101 Gwynn Oak Ave. Balt. 7.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 30, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Id.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11-28-55</u>		REGISTRAR'S SIGNATURE <u>Wm T Trabant</u>	
24. ADDRESS <u>Ellsworth Armacost - 4600 Liberty Hgts. Ave.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



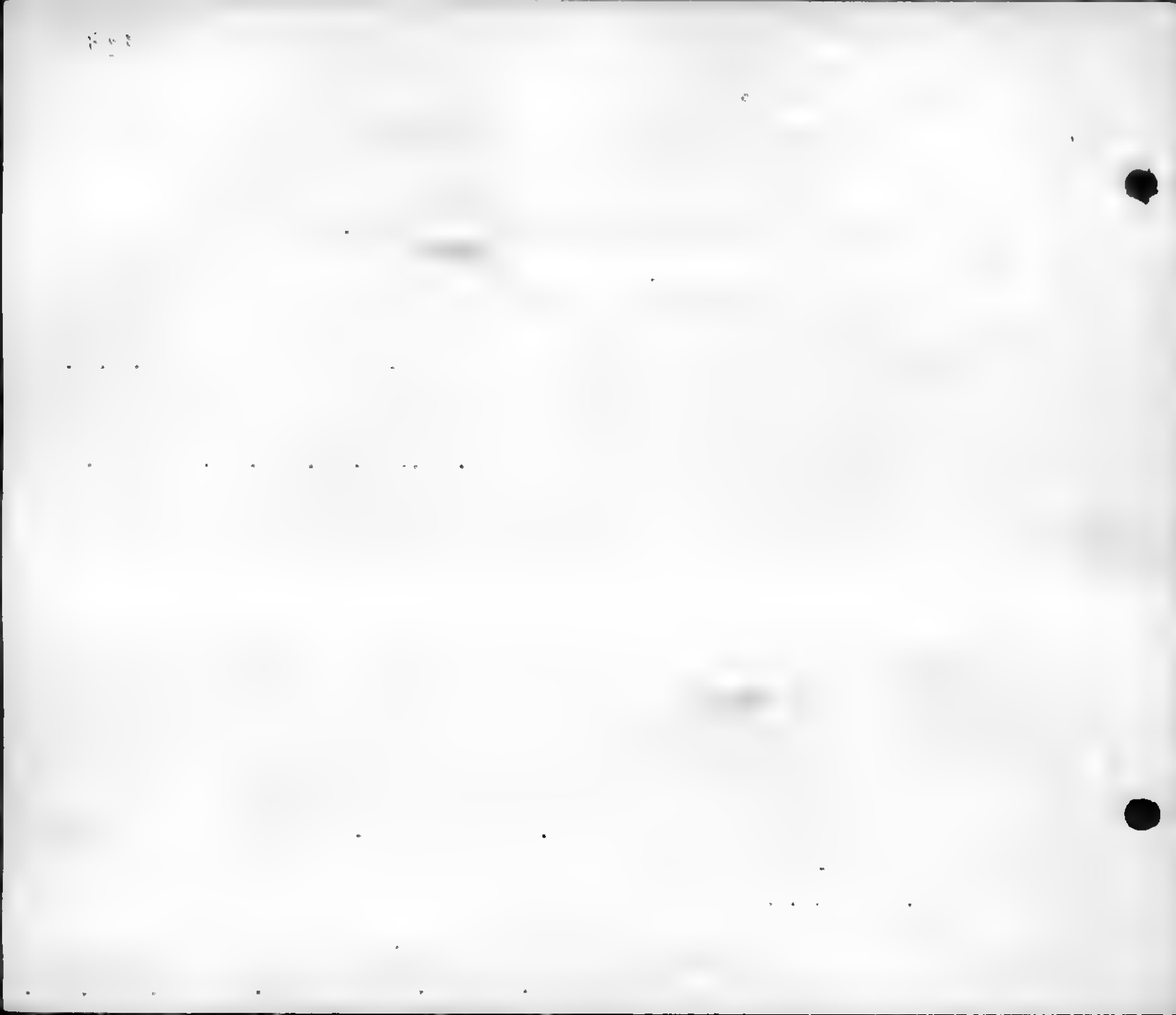
10537 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Fort Howard</u>		LENGTH OF STAY (in this place) <u>50 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1109 N. Gilmore Street</u>			
3. NAME OF DECEASED: (First) <u>LEONARD</u> (Middle) <u>D.</u> (Also (Last) <u>KELLEY</u>)				4. DATE (Month) (Day) (Year) OF DEATH: <u>November 30</u> <u>1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>4-4-13</u>	9. AGE last birthday: <u>42</u> yrs.	IF UNDER 1 YEAR: Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paper Hanger</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Self employed</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Purnell Kelly</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Brooks</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>218-07-5006</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						UNKNOWN	
(A) IMMEDIATE CAUSE (B) ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>10-27-55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Left Orchiectomy - Cystic disease of tunica vaginalis of testis, and epididymis</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>Oct. 11, 1955</u> , to <u>Nov. 30, 1955</u> , that I saw the deceased and that death occurred at <u>10:50 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>F. G. Dickey</u>				ADDRESS		DATE SIGNED	
Francis G. Dickey, M.D., Chief, Medical Service VAH, FORT HOWARD, MARYLAND 12-1-55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-5-55</u>		<u>Baltimore National Cem.</u>		<u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>12-5-55</u>		<u>AW. Hedrick</u>		<u>Mrs. Joseph A. Lively</u>		<u>661 W. Barre St. Balto. 30 Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



10538 CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>TOWSON</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>TOWSON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>106 Edgewood Road</u>		STREET ADDRESS (If rural give location) <u>106 Edgewood Road</u>	
3. NAME OF DECEASED: (First) <u>Selma</u> (Middle) <u>Young</u> (Last) <u>Kelly</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>November 1, 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Dec. 27, 1901</u>
9. AGE last birthday <u>53</u> yrs. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Paulsboro, N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Andrew Young</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Glover</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO: <u>None</u>	
17. INFORMANT & ADDRESS: <u>Arthur A. Kelly - 106 Edgewood Rd. Towson, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
175X IMMEDIATE CAUSE			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Pulmonary Embolism</u>			<u>Sudden</u>
DUE TO			
(B) <u>Thrombo-phlebitis (left leg)</u>			<u>3 days</u>
DUE TO			
(C) <u>Carcinoma of ovary</u>			<u>8 to 10 months</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>June 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Carcinoma of rt. ovary with metastasis to pelvic wall</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While at work Not while at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June</u> , 1955, to <u>Nov. 1</u> , 1955, that I last saw the deceased alive on <u>October 31</u> , 1955, and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Eileen O. Fleck</u>		DATE SIGNED <u>11/1/55</u>	
ADDRESS <u>108 Edgewood Rd. Towson</u>		M.D. <u>Nov. 3, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>Nov. 3, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Seagar & Scherer Funeral Home - Lancaster, N.Y.</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>Nov. 3, 1955</u>		REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>	
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly:



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 10537
 Reg. Dist.

No. 45

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Essex 21 Balto</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Essex</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>800 Forte Rd</u>			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
<u>Ann</u>						<u>Kemper</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F</u>	<u>W</u>		<u>Unknown</u>	<u>66 yrs</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Retired</u>		11. BIRTHPLACE (State or foreign country): <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>?</u>				14. MOTHER'S MAIDEN NAME: <u>?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>218-09-81360</u>		17. INFORMANT & ADDRESS: <u>Vaper lived on Express 800 Forte Rd</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary Occlusion</u> DUE TO <u>Arteriosclerosis H.D.</u> Antecedent cause(s) (b) <u>Arteriosclerosis H.D.</u> Diseases or conditions, if any, giving rise to the above cause DUE TO <u>Arteriosclerosis H.D.</u> stating underlying cause last (c)						<u>20 months</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE: <u>Edith A. Kelley</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11-24-55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>12-1/55</u>		NAME OF CEMETERY OR CREMATORY: <u>Oak Lawn Cemetery</u>		LOCATION (City, town, or county) (State): <u>Balto Md</u>	
DATE REC'D BY LOCAL REG. <u>12/1/55</u>		REGISTRAR'S SIGNATURE: <u>Edith A. Kelley</u>		24. FUNERAL DIRECTOR: <u>Edith A. Kelley</u>		ADDRESS:	

1.

87.

10/1/60

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10538

10540

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fort Howard</u>		<u>12 hrs. 30 mins</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>2212 Harford Rd.</u>			
3. NAME OF (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>THOMAS H. KENSSETT</u>				<u>November 13</u> <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>White</u>	<u>White</u>	<u>Married</u>	<u>6/10/89</u>	<u>66</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Inspector</u>		<u>City</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John R. Kensett</u>				<u>Annie Dryden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>Yes</u> <u>WNT</u>				<u>220-22-9247</u>		<u>Clin. Rec., Vet. Adm. Hosp. Ft. Howard Md.</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
521X IMMEDIATE CAUSE (A) <u>ABSCESS OF LUNG, RIGHT UPPER LOBE</u>						<u>UNKN OWN</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>November 12, 1955</u> , to <u>November 13, 1955</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William B. VanDegeiff, M.D.</u>				ADDRESS (Street, city, town, state) <u>Baltimore, Maryland</u>			
DATE SIGNED <u>11/14/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Nov 16, 1955</u>		<u>Baltimore National</u>		<u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>Lawson L. Farley</u>		<u>William Cook-Blight, Inc.</u>		<u>6009 Harford Rd., Balto., Md.</u>	
DATE							

FUREM V. S

RECEIVED

10541 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Catonsville				TOWN Baltimore 12			
HOSPITAL OR INSTITUTION OR STREET ADDRESS House in the Pines				STREET ADDRESS (If rural give location) 221 Dumbarton Road			
3. NAME OF DECEASED (Type or Print) David Moreland Kight				4. DATE OF DEATH November 11, 1955			
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single		8. DATE OF BIRTH Sept. 14, 1874	
9. AGE last birthday 81 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Westernport, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Samuel Kight				14. MOTHER'S MAIDEN NAME Lavinia Michael			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO			
17. INFORMANT & ADDRESS Mrs. Martha N. Baker, 221 Dumbarton Road							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Myocardial Insufficiency						12mo	
ANTECEDENT CAUSE(S) DUE TO (B) Chs Hypertensive Cardio-Vasc. Disease						10 yr. (2)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3-1 19 55 , to 11-11 19 55 , that I last saw the deceased alive on 11-10 19 55 , and that death occurred at 6:40 M., from the causes and on the date stated above.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremention				DATE THEREOF Nov. 14, 1955		NAME OF CEMETERY OR CREMATORY Green Mount Crematory	
24. REC'D BY REGISTRAR Victor E. Harry				REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tiekner & Sons, Balto., Md.	
DATE Nov. 14, 1955				ADDRESS (Street, city, town, state) M.D. 6209 Frederick Ave. Balt. 28 Md.		DATE SIGNED 11-11-55	

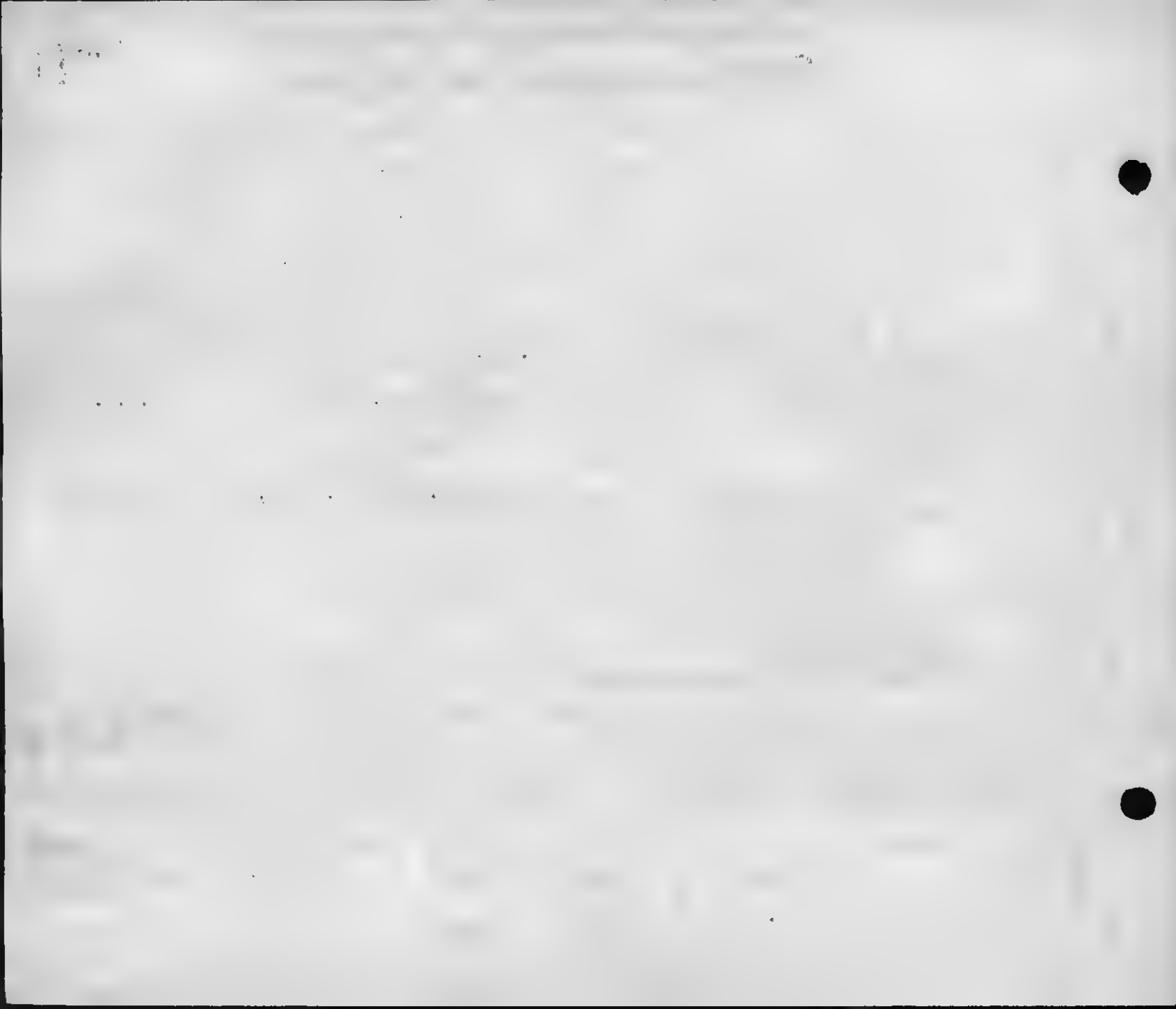
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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M



10542 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH <i>Masonic Home, Cockeysville</i>				2. USUAL RESIDENCE (HOME) OF DECEASED <i>Ind. Baltimore</i>			
COUNTY <i>Baltimore</i>		MARYLAND <i>MD</i>		STATE <i>Ind.</i>		COUNTY <i>Baltimore</i>	
(If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		(If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Cockeysville</i>				CITY OR TOWN <i>Cockeysville</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Masonic Home</i>				STREET ADDRESS <i>Masonic Home</i>			
3. NAME OF DECEASED (First) <i>George</i> (Middle) <i>E</i> (Last) <i>Kirwan</i> (<i>KIRWAN</i>)				4. DATE OF DEATH (Month) <i>11</i> (Day) <i>17</i> (Year) <i>1955</i>			
5. SEX <i>7</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widow</i>	8. DATE OF BIRTH <i>3-8-62</i>	9. AGE last birthday <i>93</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Potomac Park Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph Lynch</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth A. Rogers</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT & ADDRESS <i>L. Grace Dinnia</i>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>199.7</i>				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <i>multiple Adeno-carcinoma</i>				INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i>			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>10/13, 1955</i> to <i>Nov. 17, 1955</i> , that I last saw the deceased alive on <i>Nov. 16, 1955</i> , and that death occurred at <i>5:30 PM</i> , from the causes and on the date stated above.							
SIGNATURE <i>Walter T. Lucas</i>				ADDRESS (Street, city, town, state) <i>Cockeysville Ind</i>			
DATE <i>Nov. 29, 1955</i>				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		DATE THEREOF <i>11/1/55</i>		NAME OF CEMETERY OR CREMATORY <i>Ind. Ind.</i>		LOCATION (City, town, or county) (State) <i>Baltimore Ind</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>A. B. Hedrick</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>W. C. ...</i>		ADDRESS	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15 1-55 10M

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10541

10543

CERTIFICATE OF DEATH

Reg. Dist. No. 5

1. PLACE OF DEATH- COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u> 21		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u> 21	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>350 TOWNSEND RD.</u>		STREET ADDRESS (If rural, give location) <u>350 TOWNSEND RD.</u>	
3. NAME OF DECEASED (Type or Print) <u>WILLIAM T KNAUER</u>		4. DATE OF DEATH (Month) <u>Nov</u> (Day) <u>9</u> (Year) <u>1955</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Oct 14 1875</u>
9. AGE last birthday <u>80</u> yrs.		10. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HARRISON KNAUER</u>		14. MOTHER'S MAIDEN NAME <u>SARAH HAMILTON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>202-07-6905A</u>	
17. INFORMANT AND ADDRESS <u>Jacob W Halderman</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4221

Immediate cause

(a) —

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) —

(c) —

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH
3. 1 1/2 hrs

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/9, 1955, to 11/9, 1955, that I last saw the deceasedalive on 11/9, 1955, and that death occurred at 9:50 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATOR

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10544 CERTIFICATE OF DEATH

10542

Reg. Dist. No. 44

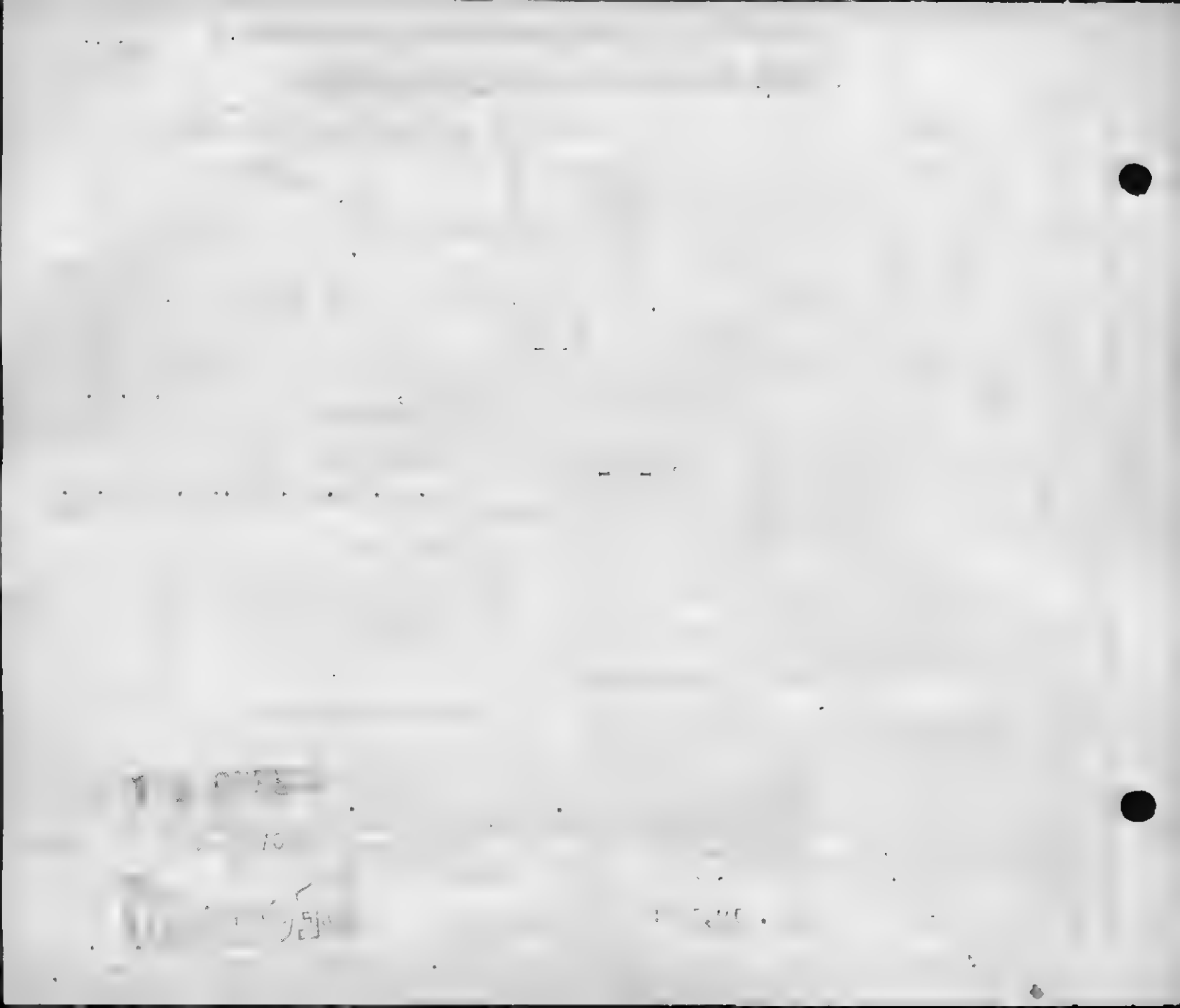
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Port Howard		LENGTH OF STAY (in this place) 9 Days		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore		TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital				STREET ADDRESS (If rural give location) 100 S. Rochester Place			
3. NAME OF DECEASED (First) (Middle) (Last) LOUIS H. KOHLBAUER				4. DATE OF DEATH (Month) (Day) (Year) November 16 1955			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 2-3-88	9. AGE last birthday 67 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ice Man		10b. KIND OF BUSINESS OR INDUSTRY Retail business		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Koplbauer				14. MOTHER'S MAIDEN NAME Mary Sparr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Yes WW I		16. SOCIAL SECURITY NO. 217-32-9167 Unknown		17. INFORMANT & ADDRESS Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 443X IMMEDIATE CAUSE (A) HYPERTENSIVE CARDIOVASCULAR DISEASE						UNKNOWN	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) _____ (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that VA attended the deceased from Nov. 7 , 19 55 , to Nov. 16 , 19 55 , and that death occurred at 8:00AM , from the causes and on the date stated above. WILLIAM B. VANDEGRIFT, M.D. ADDRESS (Street, city, town, state) VAH, FORT HOWARD, MARYLAND 11-16-55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Nov. 19, 1955		NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. REC'D BY REGISTRAR DATE 11-18-55		REGISTRAR'S SIGNATURE John A. Moran		25. FUNERAL DIRECTOR'S SIGNATURE John A. Moran ADDRESS Balto., Md. 3000 E. Baltimore St.			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10543

10545 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO. CO.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>CATONSVILLE</u>		<u>2 yr.</u>		TOWN <u>CATONSVILLE MD.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MULES CONV. HOME</u>				STREET ADDRESS (If rural give location) <u>EDMONSON + DUTTON AVE.</u>			
3. NAME OF DECEASED (Type or Print) <u>CLEMENTINE Z. LACEY</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>11/13/55</u>			
5. SEX <u>F</u>		6. CO. OR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>6/28/76</u>	
9. AGE last birthday <u>79</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRACTICAL</u>		11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>FRANK KOOKEN</u>		14. MOTHER'S MAIDEN NAME <u>ALPHA MICHAELS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>(X) Yes, give war or dates of service</u>		16. SOCIAL SECURITY NO. <u>Harold F. Lacey</u>		17. INFORMANT & ADDRESS			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>420.1 Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>hypertension</u>				<u>years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>arteriosclerosis</u>				<u>years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>-</u>		19b. MAJOR FINDINGS OF OPERATION <u>-</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov-9</u> , 19 <u>40</u> , to <u>Nov-13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov-9</u> , 19 <u>55</u> , and that death occurred at <u>7:15 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>W. E. Harry</u>				DATE SIGNED <u>Nov-13, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/17/55</u>		NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u>		LOCATION (City, town, or county) (State) <u>Westernport Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>U. E. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. Harry</u>		ADDRESS (Street, city, town, state) <u>28</u>	
DATE <u>11-15-55</u>							

Handwritten text in Arabic script, appearing to be a list or a series of notes. The text is faint and difficult to read, but some words are visible, such as "الكتاب" (the book) and "المجلد" (the volume).

Handwritten text at the bottom of the page, possibly a signature or a date. The text is very faint and mostly illegible.

10546 CERTIFICATE OF DEATH

Reg. Dist. No. 4

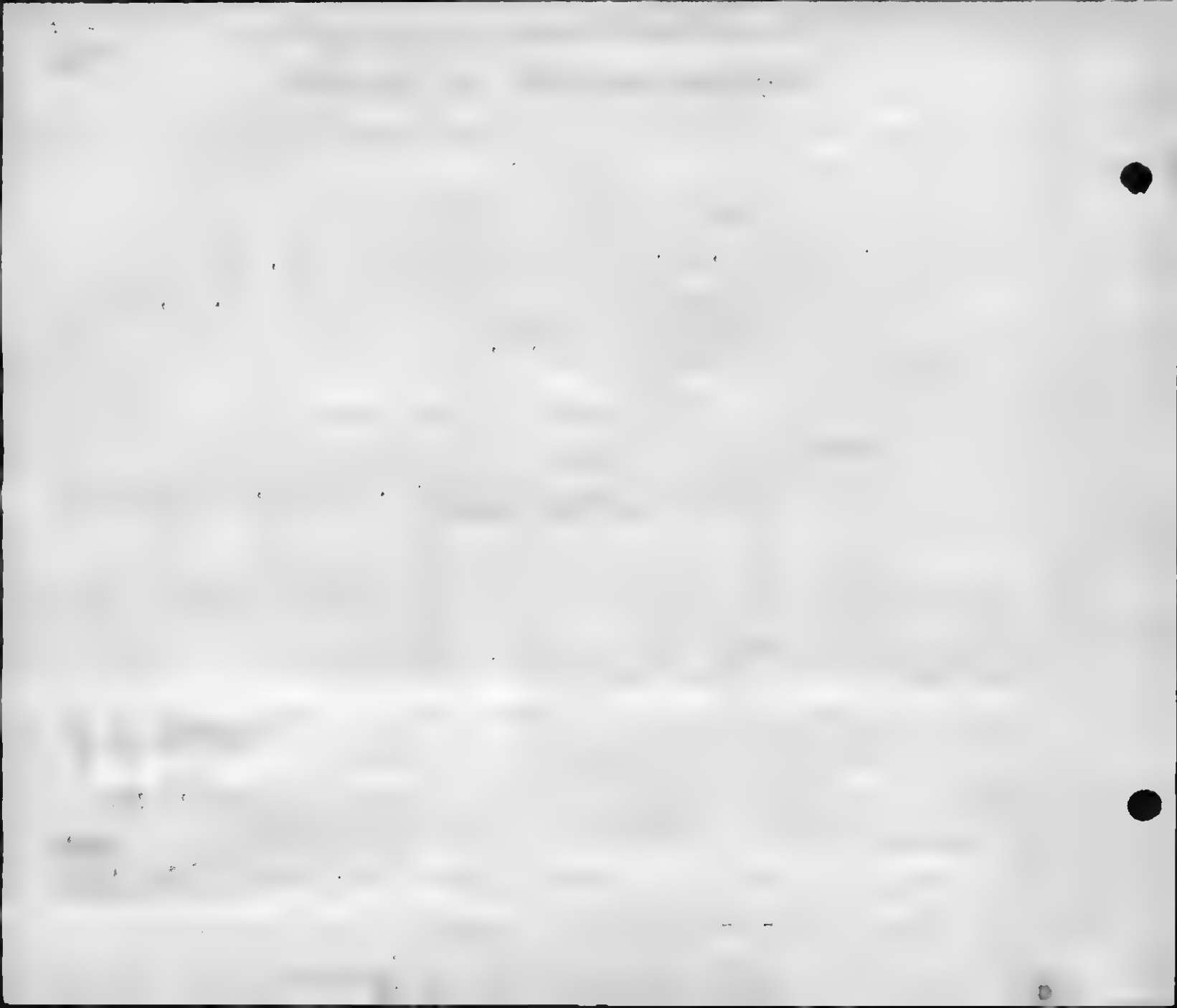
1. PLACE OF DEATH COUNTY Baltimore MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) Ivy Hill Nursing Home LENGTH OF STAY (in this place) TOWN Ivy Hill Nursing Home		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Balto. Co. CITY (If outside corporate limits, write RURAL and give nearest town) White Marsh OR TOWN White Marsh	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Middle River, Md.		STREET ADDRESS (If rural give location) Pulaski Highway, Box 587	
3. NAME OF DECEASED (Type or Print) Ernestine Lacosta (First) (Middle) (Last)		4. DATE OF DEATH Nov. 16, 1955 (Month) (Day) (Year)	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH Sept. 28, 1873
9. AGE last birthday 82 yrs.		10. IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) France		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT & ADDRESS Pierre J. Lacosta, Pulaski Highway, White Marsh, Baltimore, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 44-58 IMMEDIATE CAUSE (A) Cerebral Haemorrhage		INTERVAL BETWEEN ONSET AND DEATH 10 hours	
ANTECEDENT CAUSE(S) DUE TO (B) Hypertensive Cardiovascular disease		3 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Generalized arteriosclerosis		20 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov 15, 1955 , to Nov 16, 1955 , that I last saw the deceased alive on Nov 15, 1955 , and that death occurred at 8 A.M. from the causes and on the date stated above.			
SIGNATURE Harvey L. Fuller		ADDRESS (Street, city, town, state) M.D. Ridge Rd, Baltimore 6 Md	
DATE SIGNED Nov 16/55			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial	DATE THEREOF 11-19-55	NAME OF CEMETERY OR CREMATORY St Louis Cemetery	LOCATION (City, town, or county) (State) New Orleans, La
24. REC'D BY REGISTRAR Edith Hurley	REGISTRAR'S SIGNATURE	FEDERAL DIRECTOR'S SIGNATURE Howard H. Hubbard ADDRESS 4107 Wilkens Ave	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 415C 1-55 10M



10547 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		STREET ADDRESS		(If rural give location)	
TOWN <u>Ruxton</u>				<u>1132 E. Belvedere Avenue</u>		<u>3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sorenson Nursing Home</u> <u>7912 Ruxway Road</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>LOUISE</u> (Middle) <u>M.</u> (Last) <u>LAFFERTY</u>				(Month) (Day) (Year)			
				<u>NOV. 3, 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>female</u>	<u>white</u>	<u>Widowed</u>	<u>Nov. 17, 1869</u>	<u>85</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>housewife</u>		<u>at home</u>		<u>Baltimore, Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Ferdinand Wounghain</u>				<u>Amelia ---</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>---</u>		<u>---</u>		<u>Mrs. Blanche McCarron,</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage acute</u>						<u>6 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension Arterial Malignant</u>						<u>5 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Previous Cerebral Accident.</u>						<u>1 year</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Generalized Atherosclerosis</u>						<u>5 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
<u>none</u>		<u>no operation</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
<u>none</u>		<u>none</u>		<u>none</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>none</u>		<u>none</u>		<u>none</u>			
22. I hereby certify that I attended the deceased from <u>Oct. 21, 1955</u> , to <u>Nov. 3, 1955</u> , that I last saw the deceased alive on <u>Oct. 30, 1955</u> , and that death occurred at <u>2:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>James Graham Manton</u>				ADDRESS (Street, city, town, state)		DATE SIGNED	
M.D. <u>516 Cathedral Street</u>				<u>11-4-1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>11/5/55</u>		<u>New Cathedral Cemetery</u>		<u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
				<u>Wm. E. ...</u>		<u>1217 St. Paul Street</u>	
DATE							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-54 10A



10548

CERTIFICATE OF DEATH

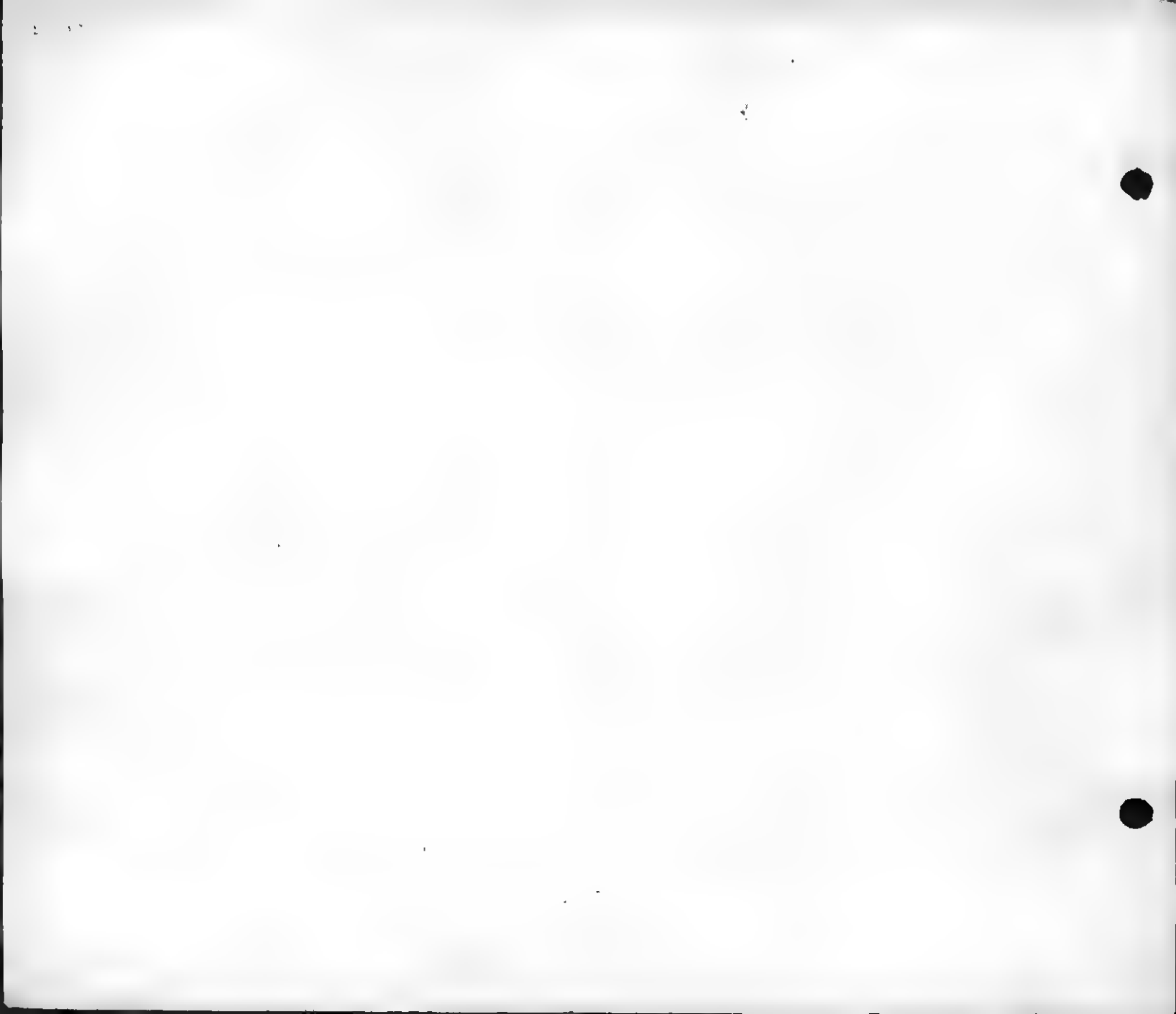
Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u> MARYLAND	STATE <u>MD</u> COUNTY	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RUXTON MD.</u> LENGTH OF STAY (in this place) <u>2 WEEKS</u>	STREET ADDRESS (If rural give location) <u>1711 LANCASTER ST</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 SORENSEN NURSING HOME 7912 RUXWAY ROAD</u>		DATE (Month) (Day) (Year) OF DEATH <u>NOV 21 1955</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>PROKOP LAITOR</u>	4. DATE OF DEATH <u>NOV 21 1955</u>		
5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u> 8. DATE OF BIRTH <u>AUG 1 1894</u> 9. AGE last birthday <u>71</u> yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>LABOR.</u> 11. BIRTHPLACE (State or foreign country): <u>RUSSIA</u> 12. CITIZEN OF WHAT COUNTRY? <u>1ST PAPERS</u>		
13. FATHER'S NAME: <u>9</u>		14. MOTHER'S MAIDEN NAME: <u>9</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-10-293 A.</u> 17. INFORMANT & ADDRESS: <u>FRANK KARDASH 2127 E PRATT ST.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Myocarditis chronic with failure</u>			<u>few</u>
ANTECEDENT CAUSE (B) <u>Myocardial hypertrophy</u>			<u>5</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Bronchial occlusion with effusion</u>			<u>years</u>
			<u>few</u>
			<u>weeks</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Advancing years</u>			
19A. DATE OF OPERATION: <u>none</u> 19B. MAJOR FINDINGS OF OPERATION: <u>none</u>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>no injury</u>		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>no injury</u>	
21C. WHERE DID (City or town) (County) (State) <u>no injury</u>		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>no injury</u> M.	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>no injury</u>	
22. I hereby certify that I attended the deceased from <u>Nov. 7, 1955</u> to <u>Nov. 21, 1955</u> , that I last saw the deceased alive on <u>Nov. 15, 1955</u> , and that death occurred at <u>5.35 P.</u> from the causes and on the date stated above.			
SIGNATURE <u>James Graham Manton</u> M.D. 516 Cathedral Street Balto Md		DATE SIGNED <u>Nov 22 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>NOV 25 55</u> NAME OF CEMETERY OR CREMATORY <u>HOLY TRINITY CEM</u> LOCATION (City, town, or county) (State) <u>ELKRIDGE MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11-25-55</u>		24. FUNERAL DIRECTOR ADDRESS <u>Duffel Bldg 1800 E LOMBARD ST</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



10547

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10549 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>BALTO. Co -</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>EDWARDS FORD</u> TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) <u>EDWARDS FORD</u> TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>231 Hopkins Road</u>		STREET ADDRESS (If rural, give location) <u>231 Hopkins Road</u>	
3. NAME OF DECEASED (Type or Print) <u>PIERCE FRANKLIN LAMBDIN</u>		4. DATE OF DEATH (Month) <u>11</u> (Day) <u>16</u> (Year) <u>55</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>69</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pay-master</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mens Hats, Inc.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>Henry Lambdin</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mr. P.J. Lambdin-231 Hopkins Rd.</u>	
17. INFORMANT AND ADDRESS <u>Mr. P.J. Lambdin-231 Hopkins Rd.</u>			

15. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
Immediate cause(a) CORONARY OCCLUSION

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

20. AUTOPSY?

Yes ☐ No ☐22. I hereby certify that I attended the deceased from Nov 16, 1955, to Nov 16, 1955, that I last saw the deceasedalive on Nov 16, 1955, and that death occurred at 6 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>11-16-55</u>	NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>	LOCATION (City, town, or county) <u>Balto. City</u>	(State)
DATE REC'D BY LOCAL REG. <u>11-16-55</u>	REGISTRAR'S SIGNATURE <u>H. W. Hedrich</u>	24. FUNERAL DIRECTOR <u>WIEDEFELD & SON</u>	ADDRESS <u>GREENMOUNT AVE & 22ND</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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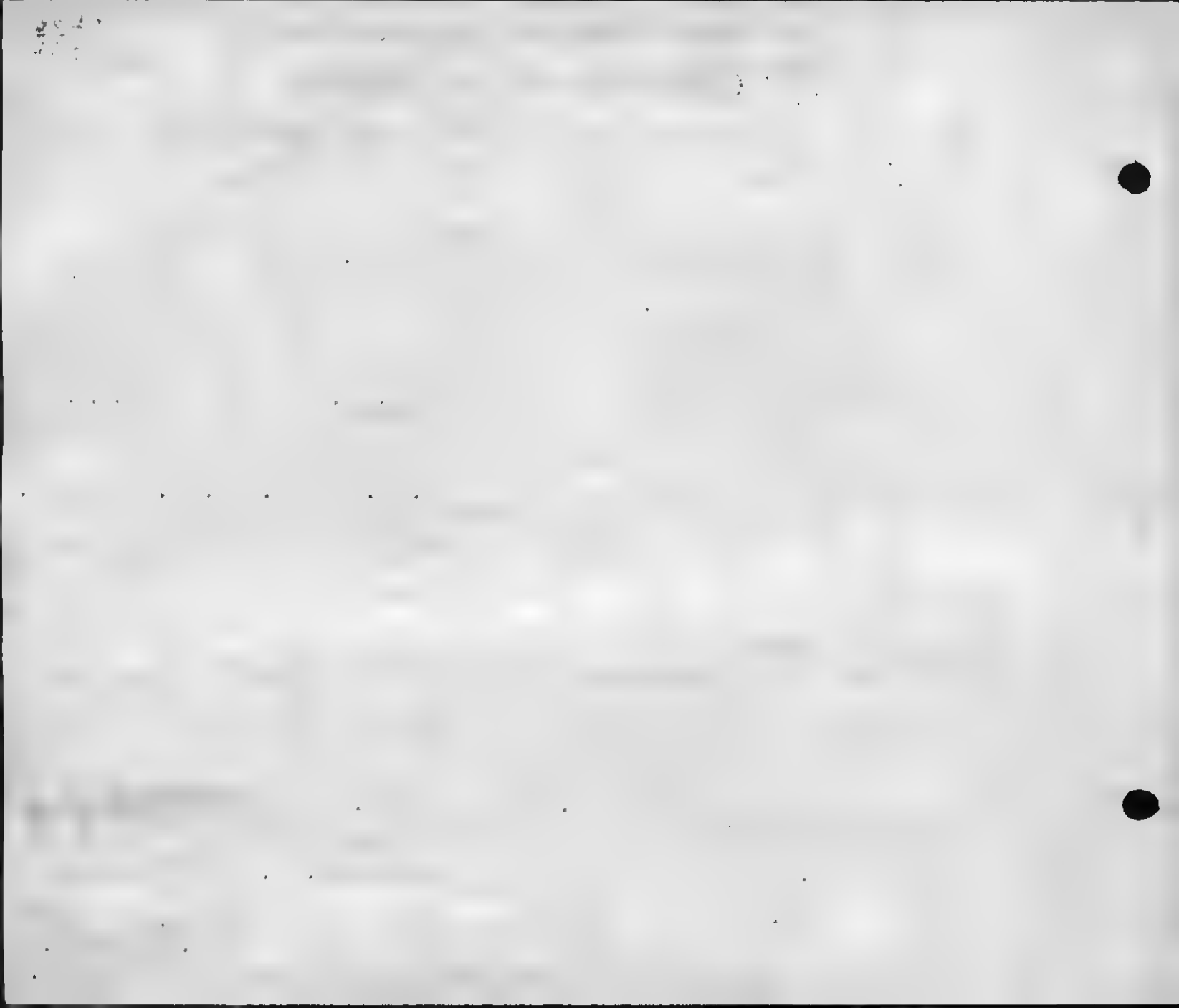
19550

CERTIFICATE OF DEATH

10548

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort Howard</u>		<u>31 days</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1715 N. Appleton Street</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>EUGENE J. LANGFORD</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>November 24 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10/6/06</u>	9. AGE last birthday <u>49</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>		11. BIRTHPLACE (State or foreign country) <u>Davisville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Washington Langford</u>				14. MOTHER'S MAIDEN NAME <u>Mattie Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>VW II</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						2 years	
5/22 X IMMEDIATE CAUSE (A) <u>Chronic Glomerulonephritis</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that VA attended the deceased from <u>Oct. 24</u> , 19 <u>55</u> , to <u>Nov. 24</u> , 19 <u>55</u> , that on <u>Nov. 24</u> , 19 <u>55</u> , the deceased died, and that death occurred at <u>10:05 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Constantine J. Palastadt</u>				ADDRESS (Street, city, town, state) <u>Fort Howard, Md.</u>			
DATE <u>11/29/1955</u>				DATE SIGNED <u>Nov 24, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/29/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		LOCATION (City, town, or county) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>Dawson L. Larkley</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>321 N. Schroeder St.</u>		ADDRESS <u>Clarence & Katie Williams Funeral Home</u>	
DATE <u>Nov. 29, 1955</u>							



10551 CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN Mt Wilson LENGTH OF STAY (in this place) 781 days
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Mt Wilson State Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Prince George's
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN Parkland 28 16X-50
 STREET ADDRESS (If rural give location) 225 1/2 Maryland Ave

3. NAME OF DECEASED:

(First) (Middle) (Last)
Agnes Theresa Lanier

4. DATE (Month) (Day) (Year) OF DEATH:

Nov-7 1955

5. SEX:

F

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Married

8. DATE OF BIRTH:

6-28-08

9. AGE last birthday:

47 yrs.

IF UNDER 1 YEAR Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country):

Dist. of Columbia

12 CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME:

John H. Brightley

14. MOTHER'S MAIDEN NAME:

Rose Heck

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO

None

17. INFORMANT & ADDRESS:

Mt. Wilson St. Hosp Hospital Records, Mt. Wilson, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A)

Pulmonary Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

15 years

ANTECEDENT CAUSE (B):

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

M.

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 17, 1953 to Mar 7, 1955 that I last saw the deceased

alive on Mar 7, 1955, and that death occurred at 10:30 PM, from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

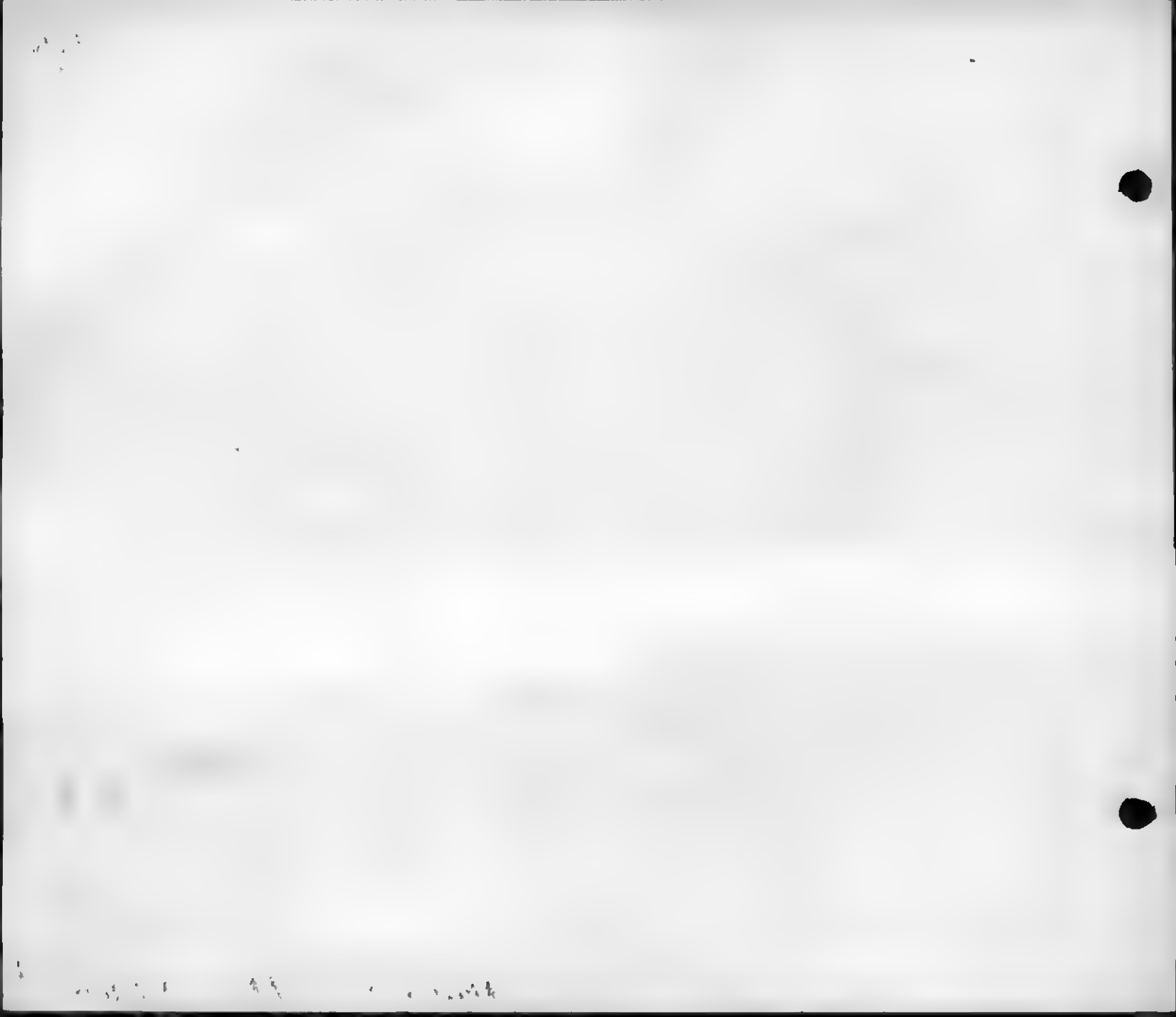
24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10550

10552 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fort Howard</u>		<u>85 days</u>		TOWN <u>Dundalk</u>		5	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>6785 Woodley Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>EBBIN</u> (Middle) <u>P</u> (Last) <u>MASTER</u>				(Month) <u>November</u> (Day) <u>16</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>4/6/97</u>	<u>58</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Engineer</u>		<u>City</u>		<u>Tennessee</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James</u>				<u>Verbie Hall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or null) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u> <u>WWI</u>		<u>219-26-2355</u>		<u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>BRONCHOGENIC CARCINOMA</u>						<u>1 YEAR</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. et work) (Not while at work)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>August 23, 1955</u> , <u>November 16, 1955</u> , and that death occurred at <u>7:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William M. Lavette, M.D.</u>				ADDRESS (Street, city, town, state)		DATE SIGNED <u>11/16/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/18/55</u>		<u>Baltimore National</u>		<u>Baltimore Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Nov. 18-55</u>		<u>Laurie L. Farber</u>		<u>Walter Brooks Bradley, Inc.</u>		<u>700 WILLOW SPRING RD., BALTO. 22, MD.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

77

10

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

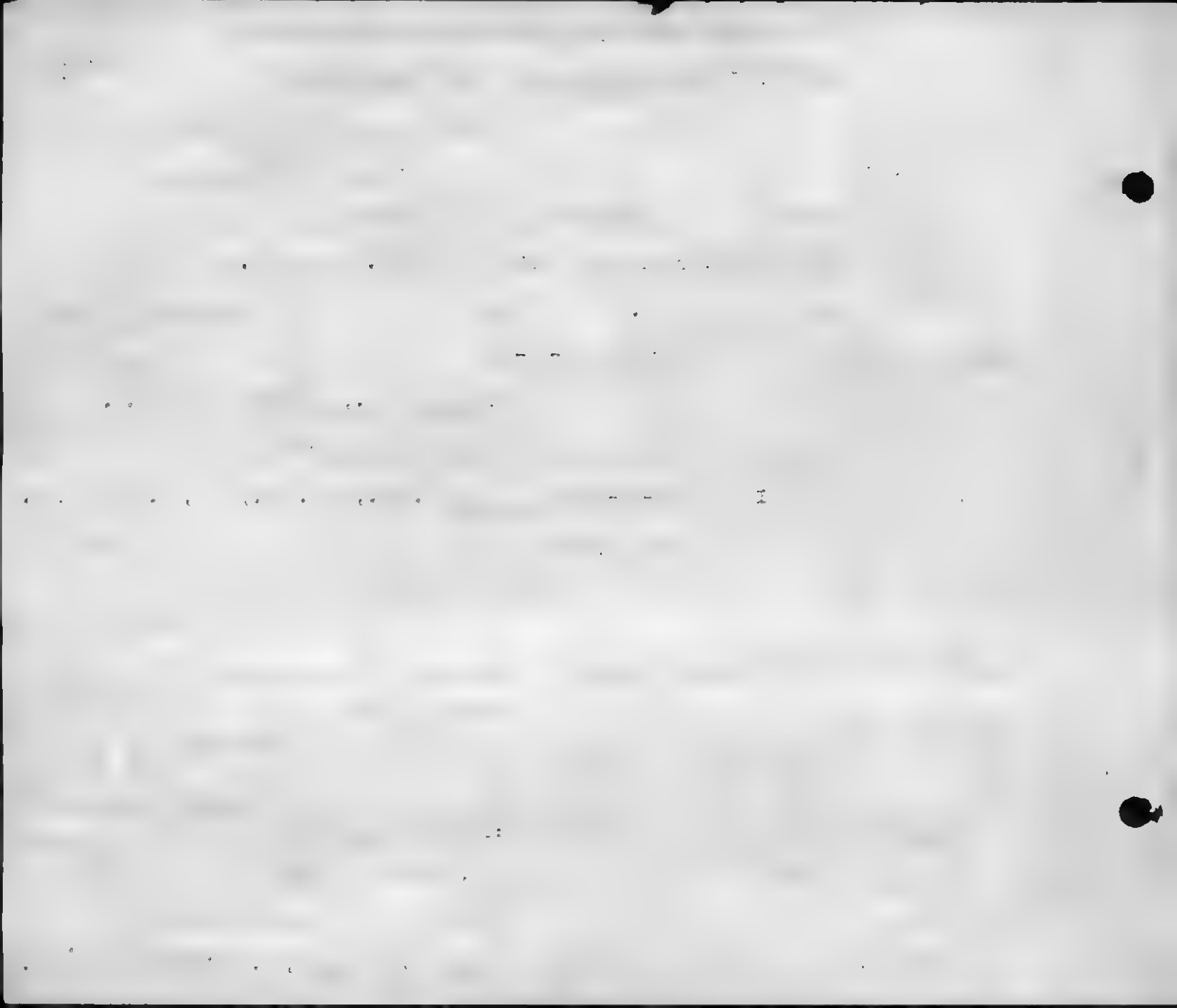
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10553 **CERTIFICATE OF DEATH**

10551

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fort Howard</u>		<u>21 days</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>534 N. Payson St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ZEALIOUS</u> (Middle) <u>A.</u> (Last) <u>LEE</u>				(Month) <u>November</u> (Day) <u>8</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6-23-92</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Longshoreman</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Lancaster Co., Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Joseph Lee</u>				14. MOTHER'S MAIDEN NAME <u>Mildred Henderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Was, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WW I</u>			16. SOCIAL SECURITY NO. <u>217-05-4068</u>		17. INFORMANT & ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>CHRONIC NEPHRITIS</u>						<u>UNKNOWN</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>✓</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>October 18 1955</u>, to <u>November 8 1955</u>, that I have the deceased under my care for <u>18 days</u>, and that death occurred at <u>6:00 AM</u>, from the causes and on the date stated above.							
SIGNATURE <u>William B. Vandegriest</u>				ADDRESS (Street, city, town, state)		DATE SIGNED <u>11/8/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-10-55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Dawson L. Farley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel W. Sullivan, Jr.</u>		ADDRESS <u>1011 Arlington Ave. Balto. Md</u>	
DATE <u>Nov 9, 1955</u>							



10554

CERTIFICATE OF DEATH

10552

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY
CITY (If outside corporate limits, write RURAL LENGTH OF TOWN OR and give nearest town) <i>Baltimore</i>	(in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Baltimore</i>	3 Yr. 4
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Wayne Conv. Home</i>		STREET ADDRESS (If rural give location) <i>901 E. Arlington Ave</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <i>Benjamin</i>	(Middle)	(Last) <i>Lenovitz</i>	(Month) <i>11</i> (Day) <i>12</i> (Year) <i>1955</i>
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>W</i>	8. DATE OF BIRTH: <i>Oct 16, 1869</i>
9. AGE last birthday: <i>86</i> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Liquor Store</i>	
11. BIRTHPLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY: <i>USA</i>	
13. FATHER'S NAME: <i>Lenovitz</i>		14. MOTHER'S MAIDEN NAME: <i>Esther</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: <i>Henry Lenovitz - 4810 Denmore Ave</i>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <i>Hemiplegia left</i>			
Antecedent causes (s) (b) <i>Generalized Arteriosclerosis</i>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)			
11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY ?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR ?			
22. I hereby certify that I attended the deceased from <i>11/8/55</i> , 19... to <i>11/12/55</i> , 19..., that I last saw the deceased alive on <i>11/12/55</i> , 19..., and that death occurred at <i>7:10 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Dr. G. H. Smith M.D.</i>		DATE SIGNED <i>12 Nov 55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
DATE THEREOF <i>11/13/55</i>		LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
REGISTRAR'S SIGNATURE <i>Dr. G. H. Smith</i>		ADDRESS <i>1124-26 W. North Ave</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

.. 5-983~

RECEIVED

NOV 10 1955

RECEIVED

10555 CERTIFICATE OF DEATH

10553 38
Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore Co.</u> MARYLAND CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town) (in this place) 55 TOWN <u>Towson</u> 3yrs. 10mos. 15 da. HOSPITAL OR INSTITUTION OR <u>Sheppard & Enoch Pratt Hosp.</u> STREET ADDRESS <u>Towson 4, Md.</u>				STATE <u>Maryland</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> 3Y01-4 STREET ADDRESS (If rural give location) <u>3801 Dorchester Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Annie Harris Levin</u>				4. DATE OF DEATH: 11 26 19 55			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widow</u>		8. DATE OF BIRTH: <u>1879</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>		9. AGE last birthday: <u>76</u> yrs. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Roman Harris</u>				14. MOTHER'S MAIDEN NAME: <u>Lothe ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS: <u>Sylvan Levin 3507 Overbrook Rd., Pikesville, Md. Hospital Records</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) <u>Broncho pneumonia</u>							
Antecedent causes (s) (b) <u>Generalized arteriosclerosis</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Chronic Brain Syndrome due to cerebral arteriosclerosis</u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION							
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)							
HOMICIDE INJURY							
TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURRED HOW DID INJURY OCCUR?							
While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I hereby certify that I attended the deceased from Jan 11, 1952, to Nov 26, 1955, that I last saw the deceased alive on Nov 25, 1955, and that death occurred at 1:45 AM, from the causes and on the date stated above.							
SIGNATURE ADDRESS DATE SIGNED							
<u>W. E. Levin, M.D.</u> THE SHEPPARD & ENOCH PRATT HOSPITAL <u>Towson, Md.</u> 11/26/55							
23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)							
<u>Burial</u> <u>Nov 27/55</u> <u>Washington Cemetery</u> <u>Baltimore, Md.</u>							
DATE REC'D BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS							
<u>NOV 27 1955</u> <u>W. E. Levin, M.D.</u> <u>1124-26</u>							

MARGIN RESERVE FOR BINNING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

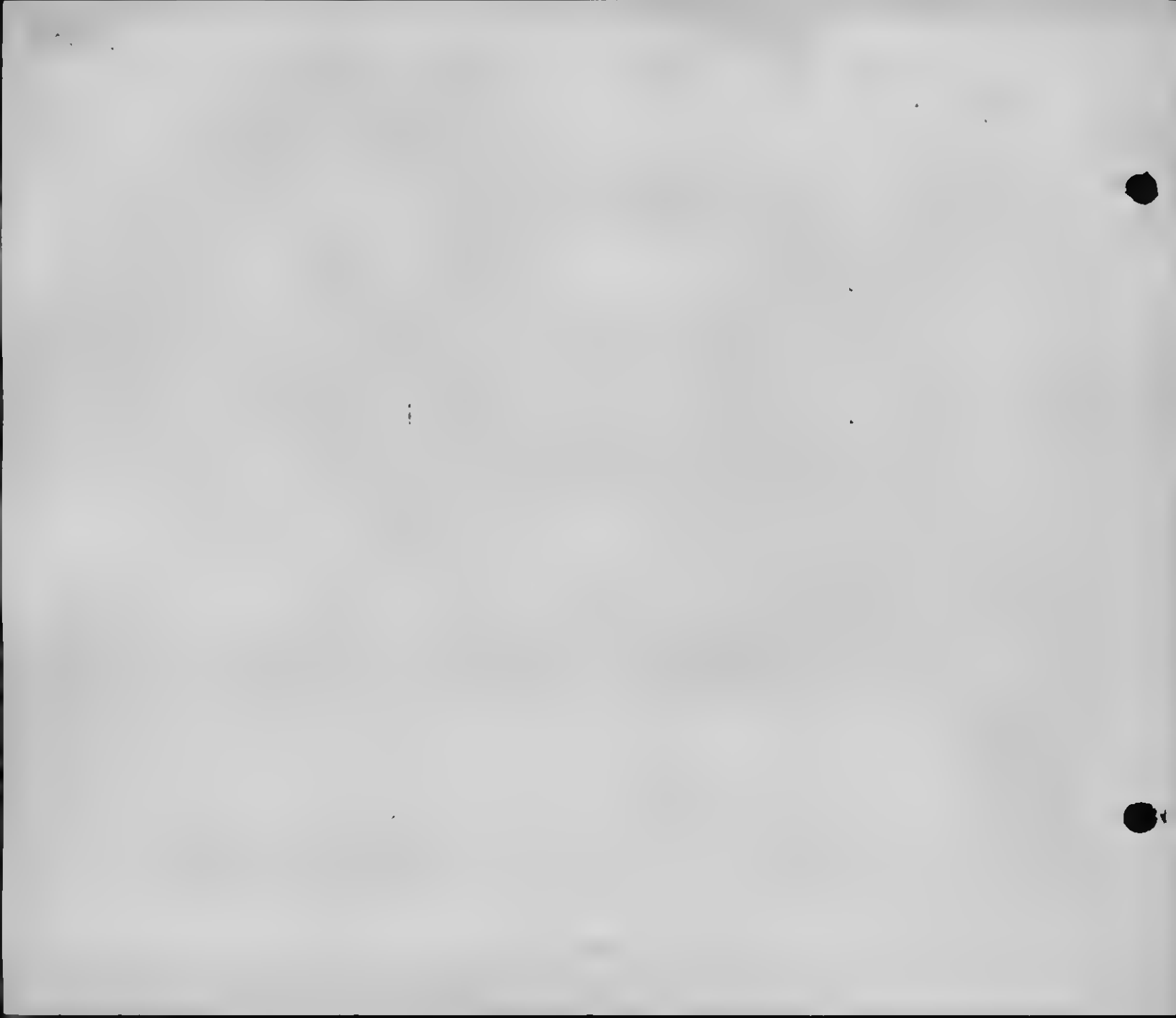
BUREAU V. S.

NOV 21 1964

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

10556				10556			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
X TOWN				TOWN <u>BALTIMORE</u>		6	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
<u>BIRD RIVER</u>				<u>4917 HAZELWOOD</u>			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
<u>CONRAD</u>		<u>Long Jr.</u>		<u>11</u>		<u>26</u> 19 <u>55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>MARRIED</u>	<u>5-4-09</u>	<u>46</u> yrs	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>HAWTHORNE MAN</u>		<u>BETH STEEL CO</u>		<u>BALTIMORE</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>CONRAD LONG SR</u>				<u>ANNIE L MALKUS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No:		17. INFORMANT & ADDRESS:			
<u>NO</u>		<u>317-63-682F</u>		<u>MILDRED LONG 4917 HAZELWOOD AVE</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.						INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u>						<u>5 min.</u>	
Immediate cause (a) <u>Cerebral Occlusion</u>							
DUE TO							
Antecedent cause(s) (b) <u></u>							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c) <u></u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE				DATE SIGNED			
<u>Jack E. Williams</u>				<u>11-27-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify):				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>BURIAL</u>				<u>NOV 29-55</u>		<u>SACRED HEART CEM</u>	
DATE REC'D BY LOCAL REG.				REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
						<u>Deppd Bros 7110 BELAIR RD</u>	



10557 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and nearest town) Pikesville (In this place) 5 yrs.
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 713 Sudbrook Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Balto.
 CITY (If outside corporate limits, write RURAL and give nearest town) Pikesville
 STREET ADDRESS (If rural give location) 713 Sudbrook Road

3. NAME OF DECEASED:

(First) (Middle) (Last)
Elizabeth - Lowe

4. DATE OF DEATH: (Month) (Day) (Year)
Nov. 15 1955

5. SEX:

Female

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Married

8. DATE OF BIRTH:

May 8, 1873

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.
82 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION: Give kind of work done during most of working life, (If retired, state so)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

At Home

11. BIRTHPLACE (State or foreign country):

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

William Schaeffer

14. MOTHER'S MAIDEN NAME:

Lowe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

ME 1-1-1-1-1-1-1-1-1-1

17. INFORMANT & ADDRESS:

John E. WhittingtonSame

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

174X
 Immediate cause

(a)

DUE TO

Heart failure

Interval Between Onset And Death

1 hr.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

Anemia secondary to hemorrhage1 year

(c)

Cancer of the Uterus3 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Atherosclerosis

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

None

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

None

(CITY OR TOWN)

None

(COUNTY)

None

(STATE)

None

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1954 to 1955, that I last saw the deceased

alive on January 1, 1955, and that death occurred at 3 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

Burial

DATE THEREOF

Nov. 18, 1955

NAME OF CEMETERY OR CREMATORY

Weston Cemetery

LOCATION (City, town, or county)

Balto. Md.

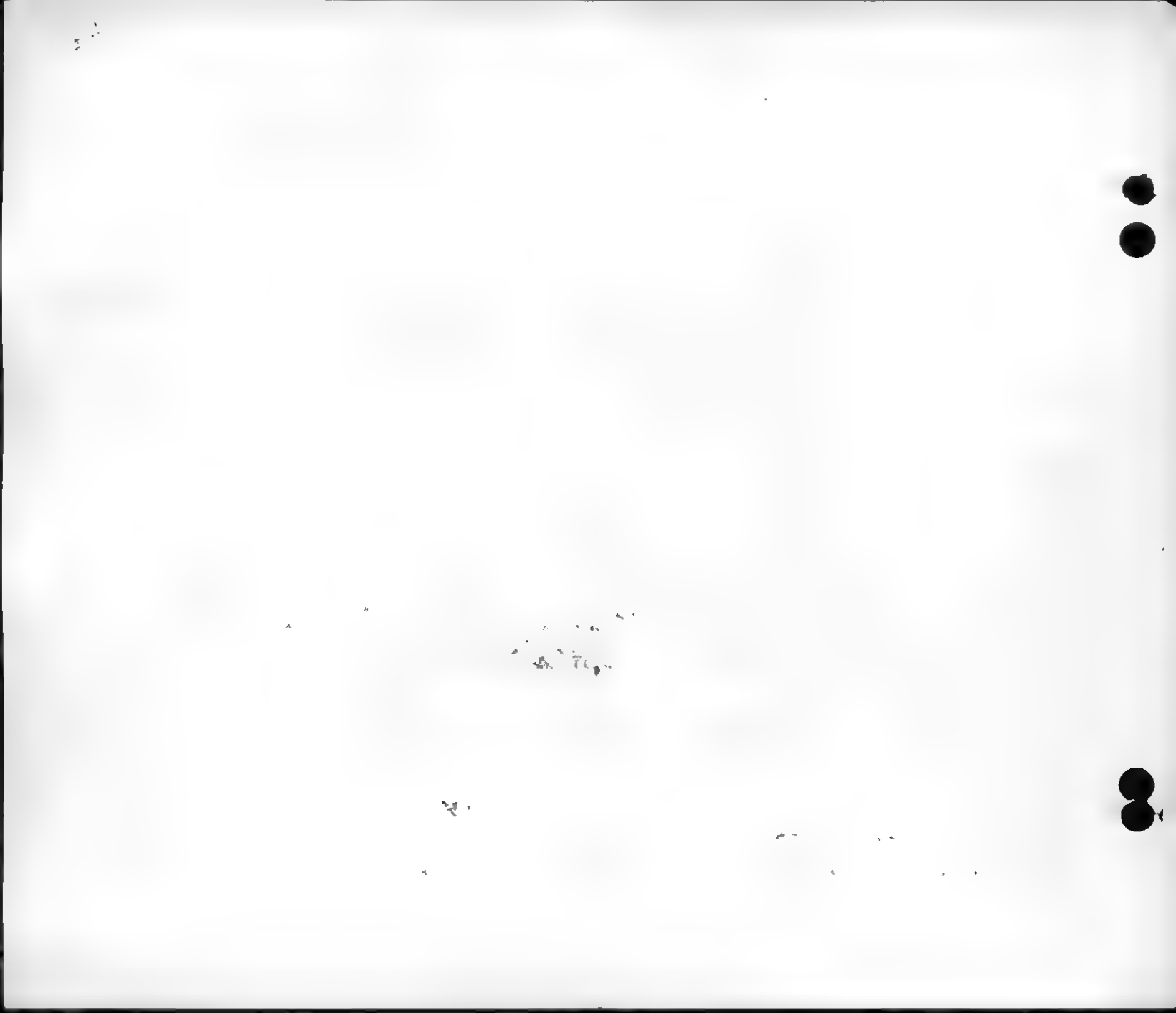
(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

GENERAL DIRECTOR

ADDRESS



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10558

CERTIFICATE OF DEATH

10558

44

Reg. Dist. No. 251

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Queen Annes</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort Howard</u>		<u>11 Minutes</u>		TOWN <u>Chester</u>		<u>1772</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>✓</u>			
3. NAME OF DECEASED (Type or Print) <u>GEORGE</u> (First) <u>E.</u> (Middle) <u>MARSHALL</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>November 29,</u> <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>9/8/99</u>	9. AGE last birthday <u>56</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Chester, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Emory Marshall</u>				14. MOTHER'S MAIDEN NAME <u>Mamie Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give year or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>218-20-8188</u>		17. INFORMANT & ADDRESS <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
4. IMMEDIATE CAUSE (A) <u>MYOCARDIAL INSUFFICIENCY</u>						<u>RECENT</u>	
ANTECEDENT CAUSE(S) DUE TO <u>ARTERIOSCLEROTIC HEART DISEASE</u>						<u>UNKNOWN</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) _____							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C) _____							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>1:24 PM</u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR? <u>1:35 PM</u>			
22. I hereby certify that I attended the deceased from <u>Nov. 29, 1955</u> to <u>Nov. 29, 1955</u> , and that death occurred at <u>1:35 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Francis G. Dickey</u>				ADDRESS (Street, city, town, state) <u>Fort Howard, Maryland</u>		DATE SIGNED <u>11-30-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 2</u>		NAME OF CEMETERY OR CREMATORY <u>Stevensville Cemetery</u>		LOCATION (City, town, or county) (State) <u>Stevensville, Maryland</u>	
24. REC'D BY REGISTRAR <u>Dec. 1</u>		REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane Funeral Home, Church Hill, Md.</u>			

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

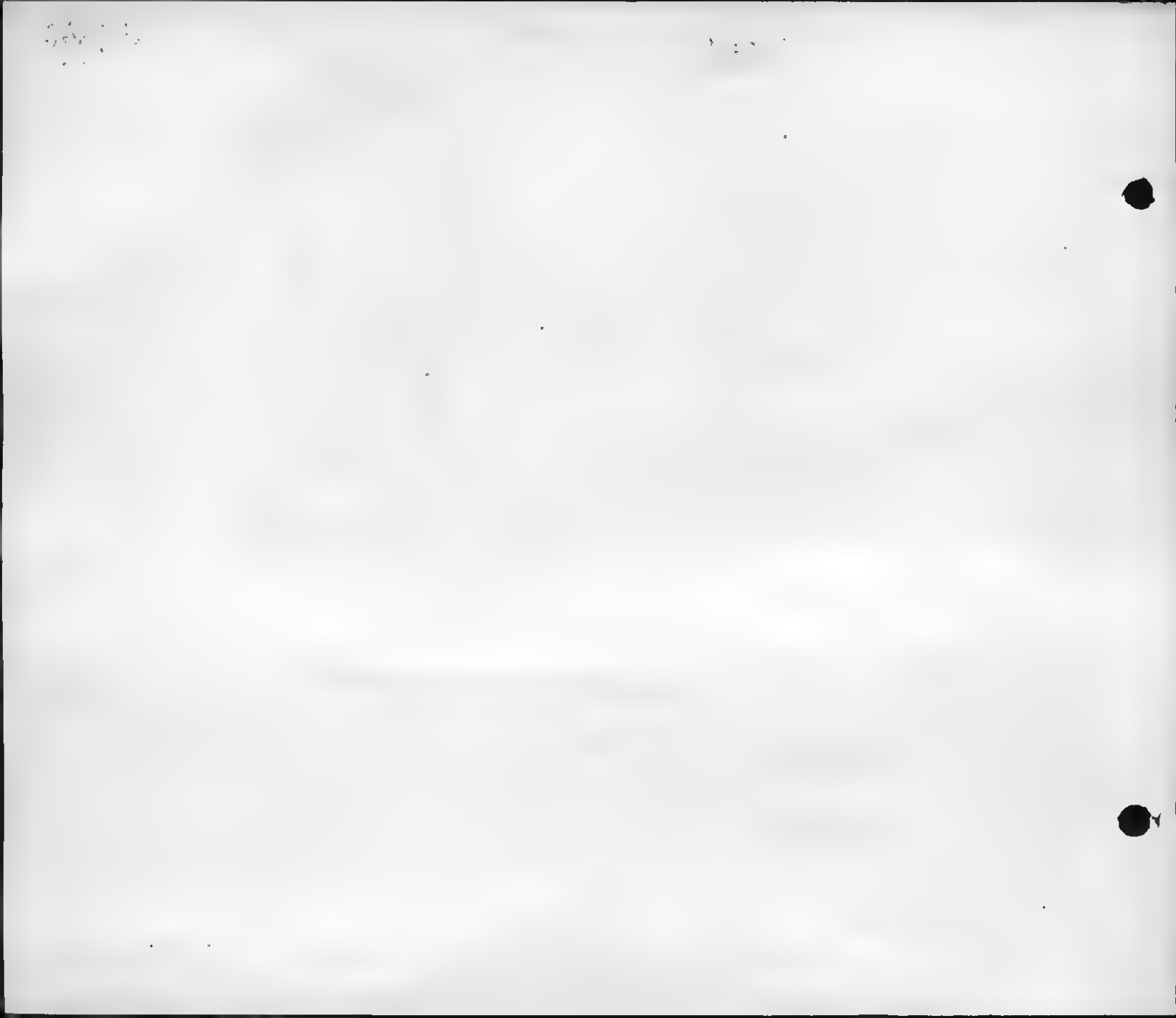
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10559

10559 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
TOWN <u>Riderwood</u>				Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sorenson Nursing Home</u>				STREET ADDRESS (If rural give location) <u>3008 Cresmont St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>CLARA M. MATHES</u>				<u>Nov. 24, 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR: Months	IF UNDER 24 HRS.: Days	IF UNDER 34 HRS.: Hours
<u>female</u>	<u>white</u>	<u>widowed</u>	<u>Aug. 4, 1873</u>	<u>82</u> yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>housewife</u>		<u>at home</u>		<u>Md.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Justin Sachs</u>				<u>Mary Berger</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO		17. INFORMANT & ADDRESS:			
<u>no</u>		<u>none</u>		<u>Rd. Mrs. Virginia N. Toohill-2541 Pickwick</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
<u>Myocardial failure acute.</u>						<u>few days</u>	
ANTECEDENT CAUSE (B):				(B) DUE TO			
<u>Myocarditis chronic</u>						<u>5 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C) DUE TO			
<u>Myocardial hypertrophy</u>						<u>4 weeks</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Diabetes generalized.</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>none</u>		<u>no operation</u>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
		<u>none</u>		<u>none</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
<u>none</u>		<u>M.</u>		<u>no injury</u>			
22. I hereby certify that I attended the deceased from <u>Sep 16 19 55</u> to <u>Nov 24, 19 55</u> , that I last saw the deceased <u>alive on Nov 22, 19 55</u> , and that death occurred at <u>7:25</u> M, from the causes and on the date stated above.							
SIGNATURE <u>James Graham Martin</u>				DATE SIGNED <u>II-25-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/26/55</u>		<u>Loudon Park Cem.</u>		<u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11-25-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>Balto 17 Md</u>	



10560

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>		COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Ft HOWARD</u>		<u>113 DAYS</u>		TOWN <u>CHOPTANK</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>ALEXANDER S. McDONALD</u>				<u>NOVEMBER 26 1955</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>MARRIED</u>		8. DATE OF BIRTH: <u>9/23/96</u>	
9. AGE last birthday <u>59</u> yrs		10. KIND OF BUSINESS OR INDUSTRY: <u>FISHERMAN</u>		11. BIRTHPLACE (State or foreign country): <u>PASS CHRISTIAN, MISS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>ALXANDER McDONALD</u>				14. MOTHER'S MAIDEN NAME: <u>ROSE De-ETZ</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If Yes, give war or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO. <u>218-20-1351</u>			
17. INFORMANT & ADDRESS: <u>CLIN. PEC., VET AT HOSP., FT. HOWARD, MD.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>15 MONTHS</u>	
<u>177X</u>							
IMMEDIATE CAUSE (A) <u>CARCINOMA OF PROSTATE</u>							
ANTECEDENT CAUSE (B):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION.				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Aug. 5, 1955, to Nov. 26, 1955, that I last saw the deceased alive on Nov. 26, 1955, and that death occurred at 2:25 P M, from the causes and on the date stated above.							
SIGNATURE <u>William B. Vandergrift, M.D.</u>				ADDRESS <u>VAH, FORT HOWARD, MD.</u>		DATE SIGNED <u>11/27/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Nov 30, 1955</u>		<u>CHOPTANK</u>		<u>CHOPTANK, MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>NOV 29 1955</u>		<u>William B. Vandergrift</u>		<u>WM. COOK-BLIGHT FUNERAL HOME INC.</u>		<u>6009 Harford Rd., Baltimore, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



10561 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH 4915 Ruxway Road		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Riderwood</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sorersen Nursing Home</u> <u>Ruxway Nursing Home</u>	MARYLAND LENGTH OF STAY (in this place)	STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson</u> STREET ADDRESS (If rural give location) <u>32 Willow Avenue</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Elle Davis McGree</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>November 29, 19 55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>Dec. 16, 1871</u>
9. AGE last birthday: <u>83</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR: Months Days Hours Mln.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Seamstress</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Self Employed</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Archibald Davis</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Hines</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Francis Davis, 32 Willow Ave., Towson, Md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
4-22-2 IMMEDIATE CAUSE		(A) <u>Myocardial failure acute</u> DUE TO <u>few hours</u>	
ANTECEDENT CAUSE (S)		(B) <u>Myocarditis chronic</u> DUE TO <u>2 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C) <u>Myocardial hypertrophy</u> DUE TO <u>5 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pericarditis with fixation & y</u>			
19A. DATE OF OPERATION: <u>none</u>		19B. MAJOR FINDINGS OF OPERATION: <u>none</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>none</u>	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>none</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR? <u>none</u>			
2 I hereby certify that I attended the deceased from <u>Oct 20, 1955</u> , to <u>Nov 22, 1955</u> that I last saw the deceased alive on <u>Nov 22, 1955</u> , and that death occurred at <u>7:25 M.</u> from the causes and on the date stated above.			
SIGNATURE <u>James Graham Manton</u>		DATE SIGNED <u>Dec. 2, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 3, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt. Marie Cemetery</u>		LOCATION (City, town, or county) (State) <u>Towson, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Dec. 2, 1955</u>		REGISTRAR'S SIGNATURE <u>John Burns Lane</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Towson, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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10454 CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY BALTO		MARYLAND		STATE MD		COUNTY BALTO	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN DUNDALK 22		14 MO.		TOWN DUNDALK 22		53	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3431 COURTWAY				STREET ADDRESS (if rural give location) 3431 COURTWAY			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
MILLIE JANE MCINTYRE				11-30-1953			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
FEM.	WHITE	WIDOWED	DEC 14, 1870	84 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
COACH CLEANER				RAILROAD		INDIANA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
HILTON D. HARRIS				REBECCA SANDS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
NO				NONE		MRS. MINNIE CURL - SAME	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				15. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A)				Central embolism			
ANTECEDENT CAUSE(S) DUE TO				Arteriosclerosis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				2 days			
				4 years			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov 24, 1953, to Nov 30, 1953, that I last saw the deceased alive on Nov 24, 1953, and that death occurred at 6 AM, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
Wanda H. Anderson				33 Dundalk Ave Dundalk, Md 12/1/53			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		12-3-55		PORTLAND CEM		LOUISVILLE, KY.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Dec 2 - 1955		William M. Kelley		Walter R. Rupp		Dundalk, Md	

VS AISC 1-55 10M

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10562

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10562
Reg. Dist.

No. 45

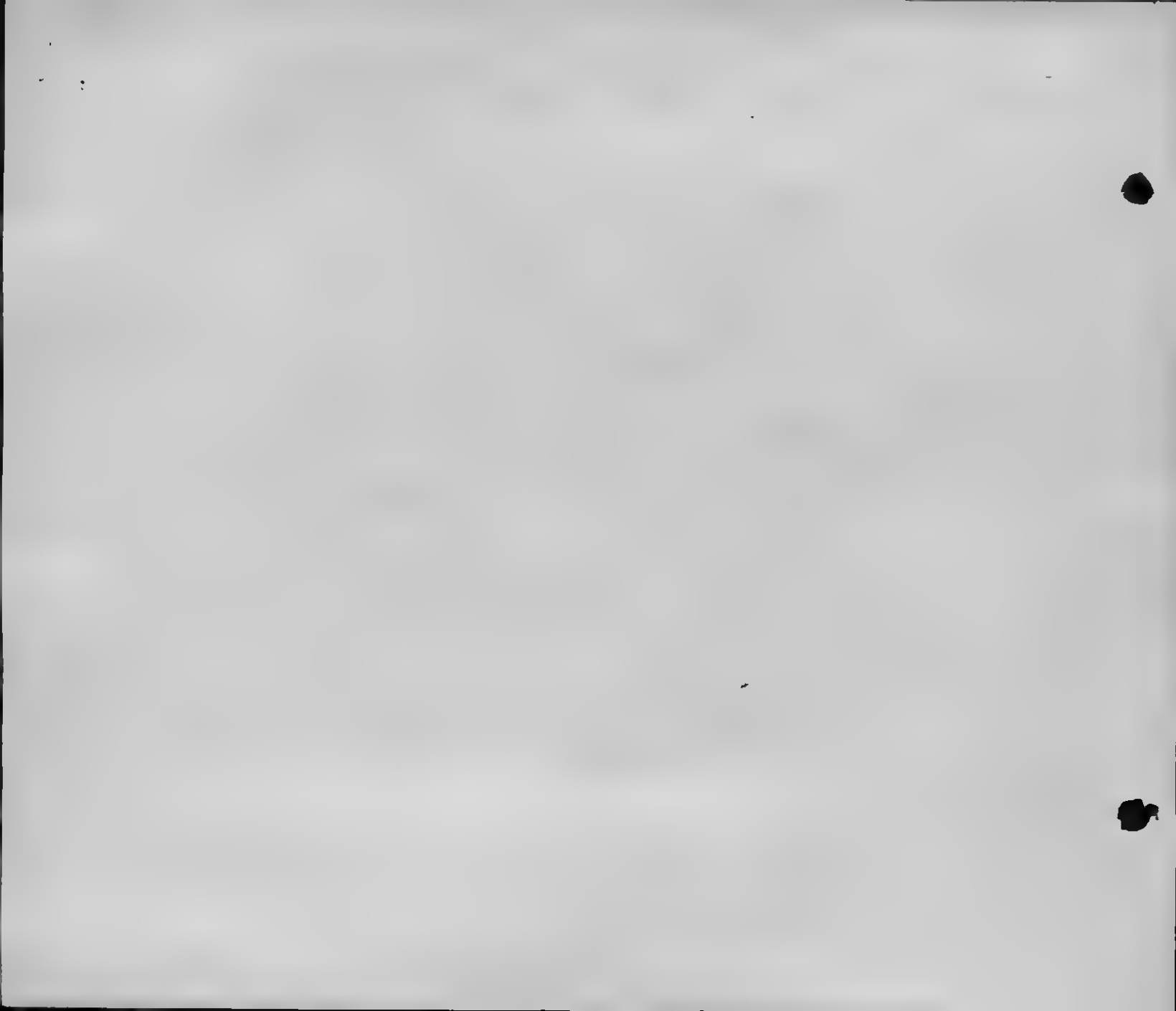
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Middle River</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Middle River</u>		STREET ADDRESS (If rural, give location) <u>2140 York Ave</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>Charles William McLean</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>11 30 1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>Black</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>3-23-1899</u>	9. AGE last birthday: <u>56</u> yrs.		IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life. If retired): <u>Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Blacksmith</u>		11. BIRTHPLACE (State or foreign country): <u>va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>William McLean</u>				14. MOTHER'S MAIDEN NAME: <u>Ella Mary Gentry</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No: <u>245-01-3571A</u>		17. INFORMANT & ADDRESS: <u>Charles William McLean</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
465X Immediate cause (a) <u>Pulmonary Embolus</u> DUE TO				<u>15 months</u>			
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>John C. Callahan</u>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <u>11-30-55</u>	
M. D.		ASSISTANT MEDICAL EXAM.					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>burial</u>		DATE THEREOF: <u>1-3-56</u>		NAME OF CEMETERY OR CREMATORY: <u>Green Grove</u>		LOCATION (City, town, or county) (State): <u>Baltimore MD</u>	
DATE REC'D BY LOCAL REG. <u>11/30/55</u>		REGISTRAR'S SIGNATURE: <u>Edith Hurley</u>		24. FUNERAL DIRECTOR: <u>W. H. McLean</u>		ADDRESS: <u>2140 York Ave</u>	



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10563		8		Items 1/2, 711-6189 12-2-55 et		10563	
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18						Reg. Dist.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Palto</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN		X	
TOWN <u>Ranchleigh</u>				TOWN <u>Balto</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		6612 CHELWOOD RD		STREET ADDRESS (If rural, give location)		6612 CHELWOOD RD	
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
(Type or Print)		<u>Anna Veronica Mchling</u>		<u>Nov</u>		<u>26</u> 19 <u>55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>SINGLE</u>	<u>FEB 18, 1885</u>	<u>77</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>HOUSEKEEPER</u>				<u>Brooklyn N.Y.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Not Known</u>				<u>Not Known</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>no</u>				<u>Raymond Klaw - Same</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause							
(b) Antecedent cause(s)							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause inst							
(c) DUE TO							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Pulmonary embolism due to phlebotrombosis</u>							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY home		21c. (City or town) (County) (State)			
				<u>6512 Chelwood Rd. Balto. Md.</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>11-26-55 6:15 p.m.</u>				<u>Found drowned in bathtub</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		<u>John F. Fisher</u>		CHIEF MEDICAL EXAMINER		DATE SIGNED	
				DEPUTY MEDICAL EXAMINER		<u>11/27/55</u>	
				M. D. ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11-29-1955</u>		<u>MOST HOLY TRINITY</u>		<u>BROOKLYN, New York</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
				<u>John F. Fisher Inc. - 2100 Eutaw Place</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10564

10564

CERTIFICATE OF DEATH

Item 12, Film G189 12-1-55

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN Hotel Cliff near Towson</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Villa Maria Glenview Rd.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN Hotel Cliff near Towson</u> STREET ADDRESS <u>Glenview Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Sister Mary Ivan Mickewicz</u>		4. DATE OF DEATH <u>November 25 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 17 1885</u>
9. AGE last birthday <u>70</u> yrs.		10. AGE last birthday If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS</u>	
11. BIRTHPLACE (State or foreign country) <u>Wilna Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Mickewicz</u>		14. MOTHER'S MAIDEN NAME <u>Franca Michalowska</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Sr. Mary Clara Hotel Cliff, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)...	<u>Coronary Thrombosis</u>	<u>Sudden</u>
Antecedent cause(s) (b)...	<u>Chronic Bronchial Asthma</u>	<u>20 yrs.</u>
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 21, 1952, to Nov. 25, 1955, that I last saw the deceased

alive on Oct. 28, 1955, and that death occurred at 5:40 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>BURIAL</u>		<u>11-28-55</u>	<u>VILLA MARIA CEMETERY</u>	<u>WILSON</u>	<u>MD.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS		
<u>11-25-55</u>			<u>915 S. YORK RD. BALTIMORE, MD.</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10565

10455 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Turner Station</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Turner Station</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>102 Oak St.</u>		STREET ADDRESS (If rural, give location) <u>102 Oak Street</u>	
3. NAME OF DECEASED (Type or Print) <u>Elizabeth</u> (First) <u>Mitchell</u> (Last)	4. DATE OF DEATH <u>11-12-</u> 19 <u>55</u>	5. SEX <u>7</u> 6. COLOR OR RACE <u>Colored</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> 8. DATE OF BIRTH <u>3-13-99</u> 9. AGE last birthday <u>56</u> yrs. If under 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Drake Branch Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Alexander Bedford</u>		14. MOTHER'S MAIDEN NAME <u>Mariah Roberts</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT AND ADDRESS <u>Frank Mitchell, 102 Oak St.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>331X</u>	(a) <u>Hypostatic pneumonia</u>	<u>2 days</u>
Antecedent cause(s) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>	(b) <u>Heart failure</u>	<u>1 week</u>
	(c) <u>Cerebral vascular accident</u>	<u>2 weeks</u>

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October 27, 1955, to November 12, 1955, that I last saw the deceased alive on November 12, 1955, and that death occurred at 1:45 A. m., from the causes and on the date stated above.

SIGNATURE: Harold Nichols, M.D. (Degree or title) ADDRESS: 7210th Avenue, Baltimore, Md. DATE SIGNED: 11/12/55

23. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>	DATE THEREOF <u>11-15-55</u>	NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Park</u>	LOCATION (City, town, or county) <u>Balto. Co., Md.</u> (State)
DATE REC'D BY LOCAL REG. <u>11/14/55</u>	REGISTRAR'S SIGNATURE <u>Charles R. Law</u>	24. FUNERAL DIRECTOR ADDRESS <u>802 Madison Ave.</u>	

IMAGE RESERVED FOR INDEXING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



10565

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Overlea</u>	LENGTH OF STAY (in this place) <u>18 yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Overlea</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>109 W. Elm Ave</u>		STREET ADDRESS (If rural give location) <u>109 W. Elm Ave</u>	
3. NAME OF DECEASED: (Type or Print) <u>Laurance L. Moessinger</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Nov. 2 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept 20 1886</u>
9. AGE last birthday <u>69</u> yrs.		10. AGE last birthday IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Forman Pattern Shop</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Bath Shipyard</u>	
11. BIRTHPLACE (State or foreign country): <u>Glenrock Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Allen Moessinger</u>		14. MOTHER'S MAIDEN NAME: <u>Ada Mae Bidabaugh</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-05-5257</u>	
17. INFORMANT & ADDRESS: <u>Robert L. Moessinger 109 W. Elm Ave</u>		18. MEDICAL CERTIFICATION	

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A) CORONARY ARTERY THROMBOSIS

INTERVAL BETWEEN ONSET AND DEATH

7 HRS.

ANTECEDENT CAUSE (S)

(B) CORONARY ARTERIOSCLEROSIS5 yrs +

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/6, 1953, to 11/2, 1955, that I last saw the deceasedalive on 10/7, 1955, and that death occurred at 6 A.M., from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10567

10566

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY BALTIMORE		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY BALTO.	
CITY (If outside corporate limits, write RURAL and give nearest town) None		CITY (If outside corporate limits, write RURAL and give nearest town) None	
TOWN None		TOWN None	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 401 Dunkirk Road		STREET ADDRESS (If rural, give location) 401 Dunkirk Road	
3. NAME OF DECEASED (Type or Print) ALONZA D. MORRIS		4. DATE OF DEATH 11/4/55	
(First) (Middle) (Last)		(Month) (Day) (Year)	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 1887
9. AGE last birthday 68 yrs.		10. BIRTHPLACE (State or foreign country) Baltimore, Md.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Wk.		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME A.D. Morris		14. MOTHER'S MAIDEN NAME (?) Shipley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. -	
(If yes, give war or dates of service)		17. INFORMANT AND ADDRESS Mrs. Mildred M. Collins-401 Dunkirk	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 28 hrs.
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 Immediate cause (a) Coronary Thrombosis		
Antecedent cause(s) (b) Hypertensive Cardio- Renal Vascular Disease		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from May 1953 , to Nov 4, 1955 , that I last saw the deceased alive on Nov 4, 1955 , and that death occurred at 3:30 m., from the causes and on the date stated above.		
SIGNATURE Charles F. Donnell		DATE SIGNED Nov 11/55
(Degree or title)		ADDRESS
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 11/7/55	NAME OF CEMETERY OR CREMATORY Holy Redeemer Com.
LOCATION (City, town, or county) Balto. Md.	(State)	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR WIEDEFELD & SON
		ADDRESS GREENMOUNT AVE & 22ND ST.

MARGIN RESERVED FOR BINING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully! The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10568

10567 CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>		LENGTH OF STAY (In this place) <u>6 years 7 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Edgewater</u>		<u>02X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>				STREET ADDRESS (If rural give location) <u>Anne Arundel County Home</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Emmett</u> <u>Morris</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>November 7, 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>7-4-1866</u>	
9. AGE last birthday <u>89</u> yrs		IF UNDER 1 YEAR: Months Days Hours Min.		10. AGE last birthday <u>89</u> yrs		IF UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Unknown</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Unknown</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service): <u>Unknown</u>				16. SOCIAL SECURITY NO.: <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Generalized arteriosclerosis</u>						Years	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Senility</u>						Years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Dehydration</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7-</u> , 19 <u>53</u> , to <u>11-7-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11-7-</u> , 19 <u>55</u> , and that death occurred at <u>3:00A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Hella Wachler</u>				DATE SIGNED <u>11/7/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>REMOVAL</u>				NAME OF CEMETERY OR CREMATOR <u>Spring Grove State Hospital</u>			
DATE REC'D BY LOCAL REGISTRAR <u>Nov. 10, 1955</u>				REGISTRAR'S SIGNATURE <u>Victor E. Barry</u>			
24. FUNERAL DIRECTOR				ADDRESS <u>1800 E LOMBARD ST</u>			



10568

CERTIFICATE OF DEATH

10569

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>all</u>
CITY (If outside corporate limits, write OR and give nearest town) <u>Batonsville</u>	RURAL LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write OR and give nearest town) <u>Batonsville</u>	52
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>571 Maryland Ave</u>		STREET ADDRESS (If rural give location) <u>571 Maryland Ave</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Julia</u>	(Middle) <u>L.</u>	(Last) <u>Morrissey</u>	(Month) <u>11</u> (Day) <u>18</u> (Year) <u>1955</u>
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>
8. DATE OF BIRTH: <u>7/2/1871</u>		9. AGE last birthday: <u>84</u> yrs.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Housework at home</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Baltimore</u>	
11. BIRTHPLACE (State or foreign country): <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Edward Bruce</u>		14. MOTHER'S MAIDEN NAME: <u>Laura Jordan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO.: <u>-</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Louis Lubalsky 571 Maryland Ave</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Arteriosclerotic C.V.D.</u>		<u>10 years</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>-</u>		
(c) <u>-</u>		

11. OTHER SIGNIFICANT CONDITIONS		19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY ?	
Conditions contributing to the death but not related to the disease or condition causing death.						Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR ?			

22. I hereby certify that I attended the deceased from <u>Dec 11, 1955</u> , to <u>Nov 18, 1955</u> , that I last saw the deceased alive on <u>11/18, 1955</u> , and that death occurred at <u>6 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		ADDRESS <u>3325 Frederick Ave</u>	
DATE SIGNED <u>11/19/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>11/22/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		LOCATION (City, town, or county) (State) <u>3801 Frederick Ave</u>	
DATE RECD BY LOCAL REGISTRAR'S SIGNATURE <u>11/21/55 A.D. Neauch</u>		24. FUNERAL DIRECTOR <u>John J. Cowan & Son</u>	
		ADDRESS <u>Hollins St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



10570

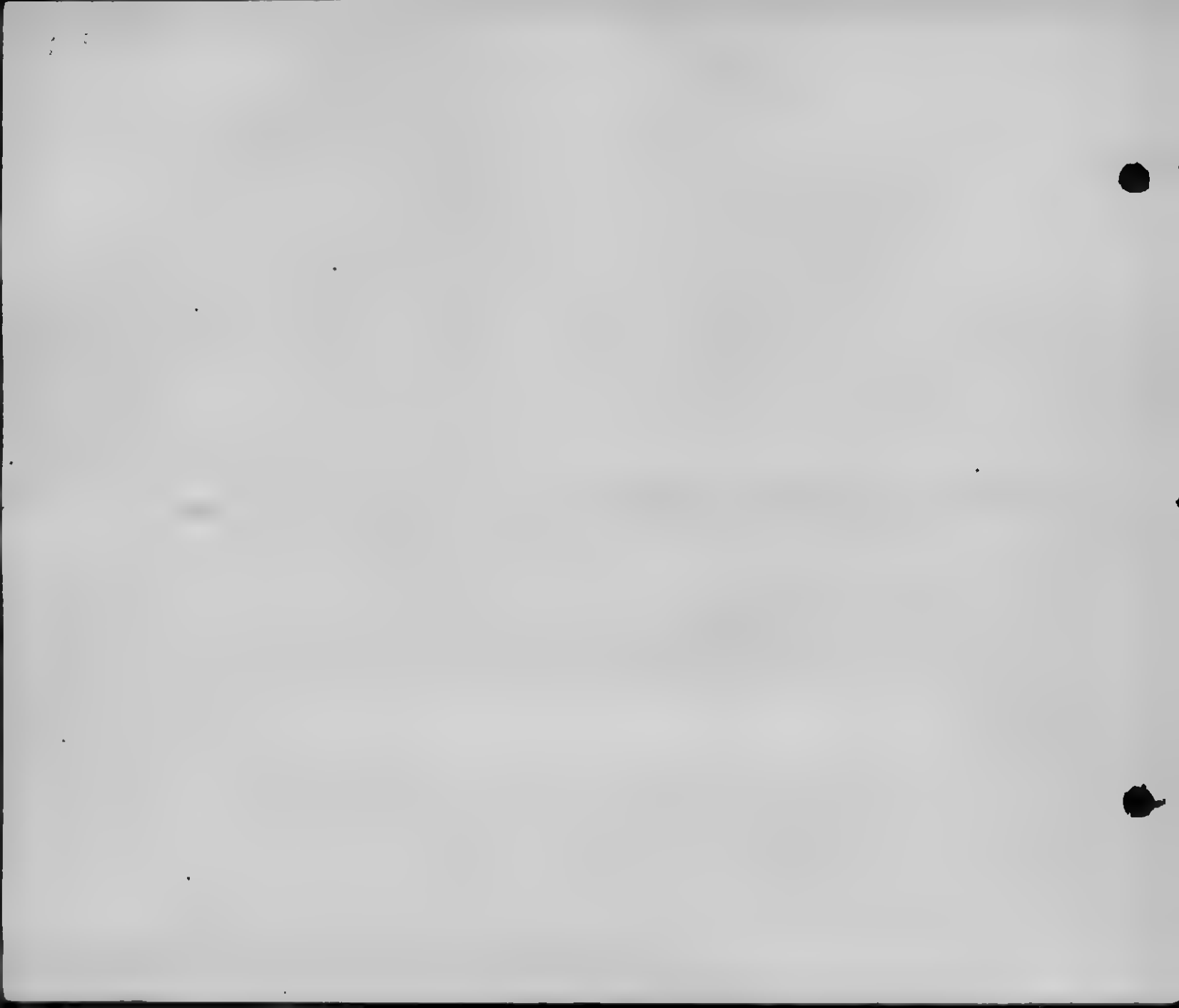
MARYLAND STATE DEPARTMENT OF HEALTH
10569 CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

Reg. Dist. No. 2

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove Hospital</u>		STREET ADDRESS (If rural, give location) <u>611 S. Wilton Avenue</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>John</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 29 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6/22/1888</u>
9. AGE last birthday <u>67</u> yrs.		10. AGE last birthday If under 1 year: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>	11. BIRTHPLACE (State or foreign country) <u>Poland</u>
12. CITIZEN OF WHAT COUNTRY? <u>Poland</u>		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>Spring Grove Hospital Records, Balto, 28 Md.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
04. Immediate cause (a) <u>Acute Cardiac Failure</u>			
Antecedent cause(s) (b) <u>Cardiovascular Disease</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Dehydration</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Fracture of right Femur</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Dental Illness</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY <u>Hospital</u>	(CITY OR TOWN) (COUNTY) (STATE) <u>Catonsville Baltimore Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Sept. 29 12:00 m.</u>		HOW DID INJURY OCCUR? <u>Was pushed on floor by another patient</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Dr. M. Kieffer MD</u>		DATE SIGNED <u>Nov. 29, 1955</u>	
23. RITUAL CREMATION (If ritual, specify) <u>Burial</u>		DATE THEREOF <u>12-3-55</u>	NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cemetery</u>
LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		24. FUNERAL DIRECTOR <u>B. Datrowski</u>	
DATE RECD BY LOCAL REG <u>12/4/55</u>		REGISTRAR'S SIGNATURE <u>W. H. Hedrick</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 10 days after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-15 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10571

10570 CERTIFICATE OF DEATH

Reg. Dist. No. 38

Item 16, Filmday 12-2-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Washington	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN X Ruxton				TOWN Hagerstown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 412 RUXWAY Ruxton Md Sorenson Nursing Home				STREET ADDRESS (If rural give location) 134 So Potomac St			
3. NAME OF DECEASED (Type or Print) OLIVER OTIS MUSCHLITZ				4. DATE OF DEATH (Month) (Day) (Year) November 8 1955			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH Sept 22 1877	9. AGE last birthday 78 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman Electrical Appliances		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Allentown Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Muschlitz				14. MOTHER'S MAIDEN NAME Elizabeth Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. 198-10-6158		17. INFORMANT & ADDRESS Mrs Hatfield B. Groves			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
44 X IMMEDIATE CAUSE (A) Acute pulmonary embolism						few hours	
ANTECEDENT CAUSE(S) DUE TO (B) Myocarditis chronic						5 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Myocardial hypertrophy						5 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Hypertension arterial general						5 years	
19a. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION none		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.) none		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) no injury			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) no injury		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. et work et work		21f. HOW DID INJURY OCCUR? no injury			
22. I hereby certify that I attended the deceased from Oct 6, 1955, to Nov 28, 1955, that I last saw the deceased alive on Nov 12, 1955, and that death occurred at 9:20 A.M. from the causes and on the date stated above.							
SIGNATURE James Graham Montan M.D. 516 Cathedral St Baltimore				DATE SIGNED II-12-1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 11/30/55		NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery Hagerstown Wash. Co. Md.		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Mabel Gray		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Nov 29, 1955				Andrew K. Coffman Hagerstown Md.			

RECEIVED

NOV

EDMUND V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10571				MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		Ref. 10572	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write OR and give nearest town) <u>Catonsville</u>		LENGTH OF STAY (In this place) <u>83 yrs</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Catonsville</u>		<u>57</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2536 Federal Rd</u>				STREET ADDRESS (If rural, give location) <u>2536 Fed. Rd</u>		<u>1</u>	
3. NAME OF DECEASED: (First) <u>Andrew</u> (Middle) <u>Phillip</u> (Last) <u>Myers</u>		4. DATE OF DEATH (Month) <u>Nov</u> (Day) <u>18</u> (Year) <u>1953</u>					
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Nov 15 1871</u>	9. AGE last birthday: <u>84</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Miller</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Flour Mill</u>		11. BIRTHPLACE (State or foreign country): <u>Md</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME: <u>Andrew Myers</u>				14. MOTHER'S MAIDEN NAME: <u>Annie Sanders</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>220 05 5067A</u>		17. INFORMANT & ADDRESS: <u>Mrs Catherine M Myers 2536 Federal</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
442X Immediate cause (a) <u>Acute cardiac failure</u>							
Antecedent cause(s) (b) <u>Cardiovascular renal disease</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Dr. Kieffer</u>		1010 Leona		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Nov 18 53</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>11-21-53</u>		NAME OF CEMETERY OR CREMATORY <u>St Mary Cemetery</u>		LOCATION (City, town, or county) (State) <u>Albester Md</u>	
DATE REC'D BY LOCAL REG. <u>11/19/55</u>		REGISTRAR'S SIGNATURE <u>T.E. Harvey</u>		24. FUNERAL DIRECTOR <u>Easton Sons</u>		ADDRESS <u>Catonsville 28 Md</u>	

375W

10572 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Catonsville</u>		<u>3 mos. 18 days</u>		TOWN <u>Bladenburg</u>		<u>10 x 10</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>				STREET ADDRESS (If rural give location) <u>5424 Spring Road</u> ✓			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Judith Maria Norberg</u>				<u>November 15, 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>2-16-1892</u>	<u>63</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Unknown</u>				<u>Sweden</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Leonard Linstrom</u>				<u>Sofia Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>Unknown</u>		<u>Records Spring Grove State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Terminal pneumonia</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO						<u>Years</u>	
STATING UNDERLYING CAUSE LAST, (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-28-</u> <u>1955</u> , to <u>11-15-</u> <u>1955</u> , that I last saw the deceased alive on <u>11-15-</u> <u>1955</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Suzella Wachter</u>		ADDRESS (Street, city, town, state) <u>Spring Grove State Hospital</u> <u>Catonsville 28, Maryland</u>				DATE SIGNED <u>11-15-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Nov 18, 1955</u>		<u>Fort Lincoln Cemetery</u>		<u>Colmar Manor Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>NOV 21 1955</u>		<u>Victor E. Barry</u>		<u>F. Gasch's Sons</u>		<u>Hyattsville, Maryland.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10573 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				10574 Reg. Dist.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 45					
1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY Baltimore		MARYLAND	STATE Maryland		COUNTY Baltimore
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Essex		LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN 54		
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7519 Lang Road		STREET ADDRESS (If rural, give location) 7519 Lang Road			
3. NAME OF DECEASED: (First) Anthony (Middle) Paul (Last) NUNLEY		4. DATE OF DEATH		5. AGE last birthday: 11 7 19 55	
6. SEX: Male	7. COLOR OR RACE: White	8. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	9. DATE OF BIRTH: Sept 1, 24-55	10. AGE last birthday: 6 weeks	11. IF UNDER 1 YEAR: Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Baltimore, Md.	
13. FATHER'S NAME: Earl Nunley		14. MOTHER'S MAIDEN NAME: Lois Bolling			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
525X Immediate cause (a) Interstitial pneumonitis DUE TO					
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)					
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE Paul P. ...		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11/7/55 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF Nov. 8-55		NAME OF CEMETERY OR CREMATORY American Legion Cem. Location (City, town, or county) Baltimore, Md. (State) Md.	
DATE REC'D BY LOCAL REG. 11/8/55		REGISTRAR'S SIGNATURE Faith Nunley		24. FUNERAL DIRECTOR John G. Connolly Address East	



10574 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balt.</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Balt.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rosedale</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sherman Nursing Home</u>				STREET ADDRESS (If rural, give location) <u>315 Chesaco Ave</u> <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Mary E. O'Donnell</u>				<u>Nov. 5 - 1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Oct. 7 - 1890</u>	9. AGE last birthday: <u>65</u> yrs.	IF UNDER 1 YEAR: Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>		11. BIRTHPLACE (State or foreign country): <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Christopher Condon</u>				14. MOTHER'S MAIDEN NAME: <u>Anne Harwood</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mrs Lottie Matheny (Adm.)</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause		(a) <u>Acute Cardiac Dilation</u>				<u>few hours</u>	
Antecedent cause(s)		(b) <u>Myocardial Hypertrophy</u>				<u>5+ yrs.</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c) <u>Myocarditis Chronic</u>				<u>5+ yrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. <u>Advanced age</u>							
19a. DATE OF OPERATION: <u>none</u>		19b. MAJOR FINDINGS OF OPERATION: <u>none</u>					
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE <u>no</u>		HOMICIDE <u>no</u>		<u>no</u>		<u>no</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 20, 1955</u> , to <u>Nov. 5, 1955</u> , that I last saw the deceased alive on <u>Nov. 1, 1955</u> , and that death occurred at <u>7:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Anna Graham Manton, M.D.</u>				(DEGREE OR TITLE) ADDRESS <u>516 Cathedral Street</u>		DATE SIGNED <u>11-7-1955</u>	
23. BURIAL, CREMATION REMOVAL (Specify): <u>Buried</u>		DATE THEREOF <u>Nov. 8-55</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>Md</u>	
DATE REC'D BY LOCAL REG. <u>11/7/55</u>		REGISTRAR'S SIGNATURE <u>C. J. Haddock</u>		24. FUNERAL DIRECTOR <u>Henry G. Connolly</u>		ADDRESS <u>Cooper, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

Dr. James. Maiston
516 Cathedral St

10575
CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town)

TOWN Parkville

HOSPITAL OR INSTITUTION OR STREET ADDRESS 7805 Clarksworth Place

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Mar land

COUNTY Balto.

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Parkville

STREET ADDRESS (If rural give location)

ADDRESS 7805 Clarksworth Place

3. NAME OF DECEASED:

(First)

SARAH

(Middle)

C.

(Last)

OSWINKLE

4. DATE OF DEATH:

(Month)

(Day)

(Year)

Nov. 7, 1955

19

5. SEX:

Female

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Widowed

8. DATE OF BIRTH:

June 28, 1877

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

78 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):

At home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

James Smith

14. MOTHER'S MAIDEN NAME:

Mary E. Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No.

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Mrs. Ruth Dill 7805 Clarksworth Place-14

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

Carcinoma of Colon, Transverse.
Generalized metastasis

Interval Between Onset And Death

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 1943, to Nov. 7, 1955, that I last saw the deceased alive on Nov. 2, 1955, and that death occurred at 7:00 AM from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

Burial

DATE THEREOF

Nov. 10, 1955

NAME OF CEMETERY OR CREMATORY

Baltimore

LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

C. J. Hedrick

24. FUNERAL DIRECTOR

ADDRESS

Ullrich Funeral Home 4210 Belair Road,

MARGIN RESERVED FOR BINDING



10576 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<u>Fort Howard</u>	<u>6 Days</u>	OR TOWN <u>Baltimore</u>	<u>4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)		
<u>Veterans Administration Hospital</u>	<u>7529 Cypress Avenue</u>		

3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>EDWARD</u>	(Middle) <u>J.</u>	(Last) <u>PAPPAS</u>	OF DEATH <u>November 16</u> <u>1955</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>8-23-22</u>
9. AGE last birthday <u>33</u> yrs.		10. IF UNDER 1 YEAR: Months Days	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Pipefitter</u>	10B. KIND OF BUSINESS OR INDUSTRY: <u>Steel Company</u>	11. BIRTHPLACE (State or foreign country): <u>Wilkes Barre, Pennsylvania</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
--	---	--	--

13. FATHER'S NAME: <u>Peter Pappas</u>	14. MOTHER'S MAIDEN NAME: <u>Rose Ward</u>
--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>	16. SOCIAL SECURITY NO. <u>138-12-3163</u>	17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>
---	--	--

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		UNKNOWN
(A) IMMEDIATE CAUSE <u>SEMINOMA OF LEFT TESTIS</u>		
(B) ANTECEDENT CAUSE (S) <u>UNKNOWN</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>6-11-55</u>	19B. MAJOR FINDINGS OF OPERATION: <u>Removal of left testis for tumor</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
--	---	--

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)
	OF INJURY	INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from Nov. 10, 1955, to Nov. 16, 1955, and that death occurred at 7:30 M. from the causes and on the date stated above.
--

SIGNATURE <u>William B. Vandegriest, M.D.</u>	ADDRESS <u>VAH, Fort Howard, Maryland</u>	DATE SIGNED <u>11-17-55</u>
---	---	-----------------------------

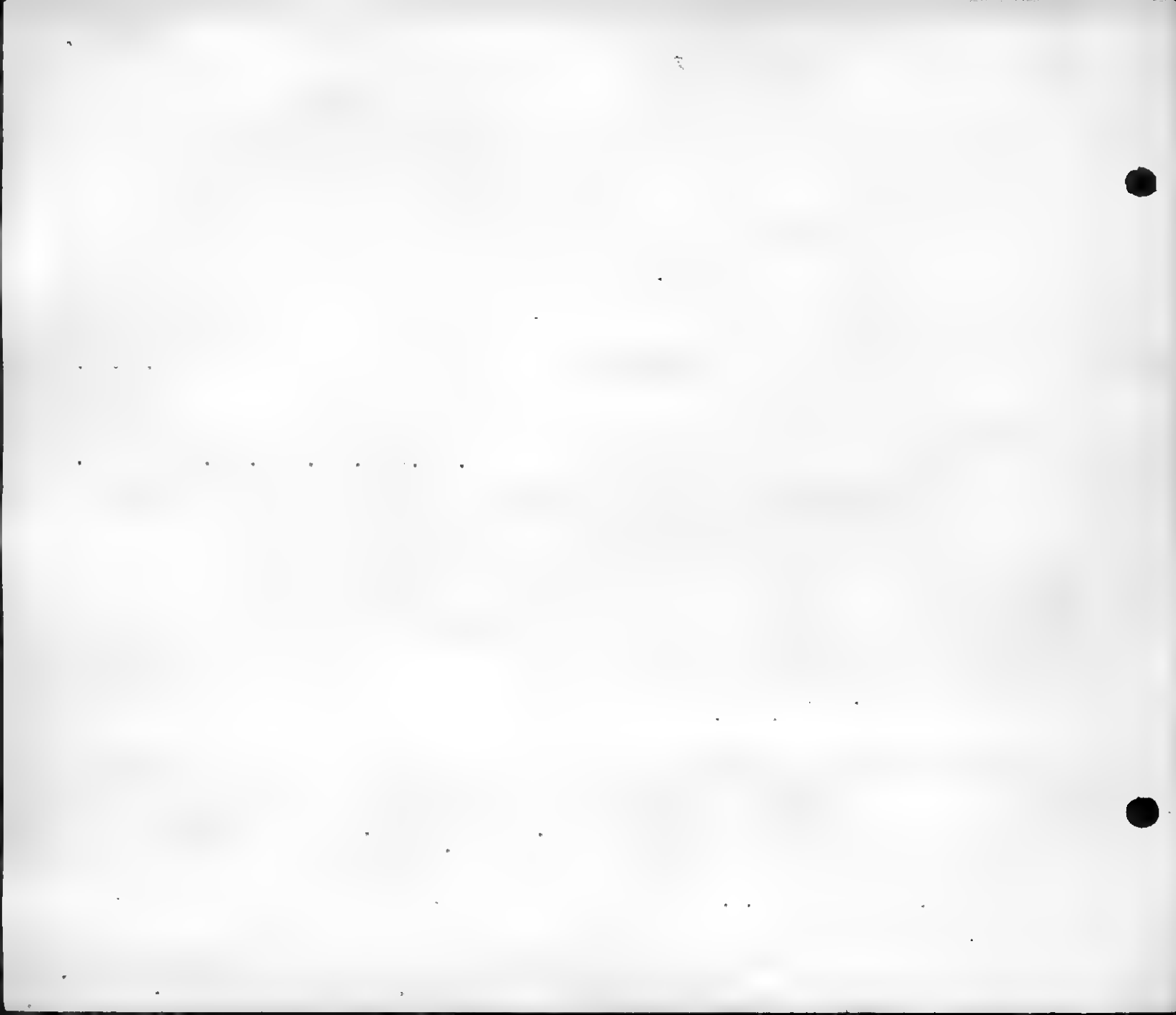
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
--	--------------	-------------------------------	--

Burial	<u>11-21-55</u>	<u>Oak Lawn Cemetery</u>	<u>Baltimore, Maryland</u>
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DATE REC'D BY LOCAL REGISTRAR <u>11-18-55</u>	REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Charles S. Zeiler Funeral Home</u>	ADDRESS <u>Baltimore, Md. 7225 Eastern Ave.</u>
---	--	--	---

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



10456 CERTIFICATE OF DEATH

1. PLACE OF DEATH:

COUNTY BALTIMORE MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) DUNDALK LENGTH OF STAY (in this place)
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 3121 SOLLERS PT. RD

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY BALTO.
 CITY (If outside corporate limits, write RURAL and give nearest town) DUNDALK
 STREET ADDRESS (If rural give location) 3121 SOLLERS POINT RD

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

ZELLA MAE PARKER

4. DATE OF DEATH:

(Month)

(Day)

(Year)

(Specify)

NOV. 211955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday:

If UNDER 1 YEAR

If UNDER 24 HRS.

FEMALEWHITEMARRIEDJAN. 1, 189065 yrs.

Months Days Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

AT HOMEDE NNAU.S.A.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

NO-MRS. THELMA BROOKMAN 3121 SOLLERS PT

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

Immediate cause

(a) DUE TO

Antecedent causes(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

Interval Between Onset And Death

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work Not While at Work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/16/55 to 11/22/55, that I last saw the deceasedalive on 11/19/55, and that death occurred at 11/22/55, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

at 9 AM

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Nov. 22-1955William M. KellyULLRICH FUNERAL HOMEDUNDALK

MARGIN RESERVED FOR INDEXING

U. S.

10.

1

10577 CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)

X TOWN R. derwood

LENGTH OF STAY
(in this place)

1 wk.

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS7912 Ruxway Road
Sorenson Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN Baltimore

(If rural, give location)

STREET
ADDRESS

4503 Manordean Road

3. NAME OF
DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

WILLIAM WATSON POWELL

4. DATE

(Month)

(Day)

(Year)

OF
DEATH:

Nov. 14

19 55

5. SEX:

Male

6. COLOR OR

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) widowed

8. DATE OF BIRTH:

April

1876

9. AGE last birthday:

79

yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of
work done during most of working life,
even if retired): Retired Lawyer10b. KIND OF BUSINESS OR
INDUSTRY:
Law11. BIRTHPLACE (State or foreign country):
Maryland12. CITIZEN OF WHAT
COUNTRY?
U. S.

13. FATHER'S NAME:

Ransom G. Powell

14. MOTHER'S MAIDEN NAME:

Margaret Watson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Mrs. H. Reynolds Powell 710 Stoneleigh Rd.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

492X
Immediate cause

(a) DUE TO

Pneumonia - bilateral

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating underlying cause last

(b) DUE TO

Virus infection of respiratory tract 6 weeks

(c)

Hypertension & arteriosclerosis
causing hemorrhage age 58 yrsINTERVAL BETWEEN
ONSET AND DEATH

3 days

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Not while
work ☐ at work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-11-1955, to 11-14-1955, that I last saw the deceased
alive on 11-13-1955, and that death occurred at 11 A.m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify):
Burial

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

11-15-55

A. L. L. H. L. L.

H. L. L.

Main St. Reisterstown, Maryland Nov. 14
Baltimore Co., Maryland
John O. Mitchell & Sons Inc. 1900 Eutaw Pl.

Dr. James Saffell

MARGIN RESERVED FOR BINDING

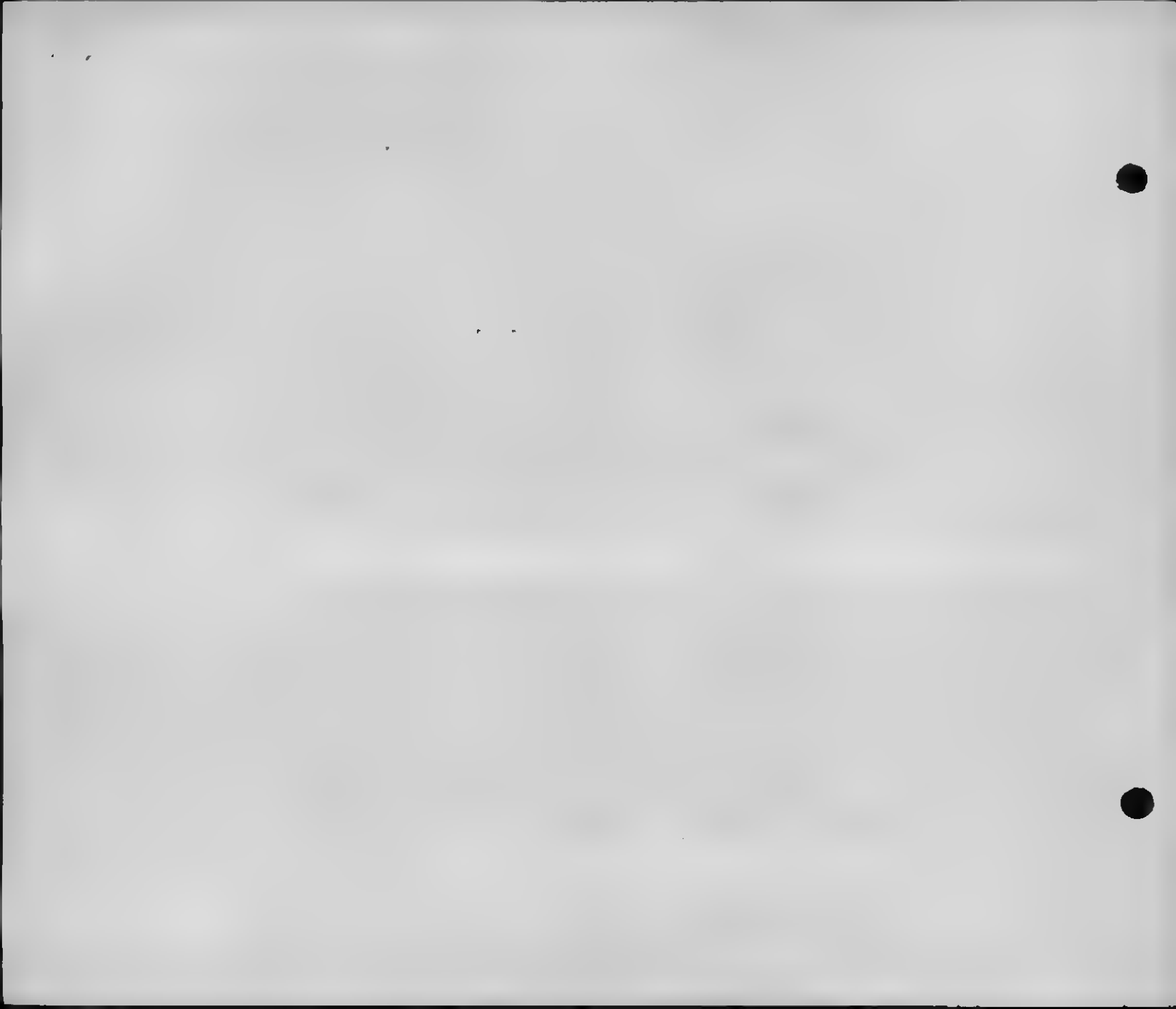
VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10578 MARYLAND, STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				10580 Reg. Dist.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.					
1. PLACE OF DEATH: <i>Chesaco Pk.</i>			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY Baltimore		MARYLAND	STATE Md.		COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)		
TOWN			TOWN Baltimore		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pulaski Highway			STREET ADDRESS (If rural, give location) 2024 Ashland Avenue		
3. NAME OF DECEASED: (First) EDWARD (Middle) <i>Anthony</i> (Last) PRICE (PRZYBYŚZEWSKI)			4. DATE OF DEATH (Month) 11 (Day) 13 (Year) 19 55		
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Aug. 1, 1908	9. AGE last birthday: 47 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Self		10b. KIND OF BUSINESS OR INDUSTRY: Restaurant	11. BIRTHPLACE (State or foreign country): Anne Arundel County		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Mateusz Przybyszewski			14. MOTHER'S MAIDEN NAME: Marianna Januchowski		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: 213-07-4491	17. INFORMANT & ADDRESS: <i>Mrs. Anna Price 2024 Ashland Ave</i>		
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a) Bronchopneumonia					
DUE TO					
Antecedent cause(s) (b) Fatty liver					
Diseases or conditions, if any, giving rise to the above cause DUE TO					
stating underlying cause last (c) Pulmonary fat embolism					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)		
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <i>William Howard</i>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 11/14/55 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF Nov. 16, 1955	NAME OF CEMETERY OR CREMATORY Holy Rosary Cmn.		LOCATION (City, town, or county) (State) Balta. County
DATE REC'D BY LOCAL REG. 11-15-55		REGISTRAR'S SIGNATURE <i>A. W. Adeline</i>		FUNERAL DIRECTOR John M. Welby ADDRESS 401 S. Chester St.	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate usually should be detached for use as a burial transit permit.

VS AISC 1-58 10M

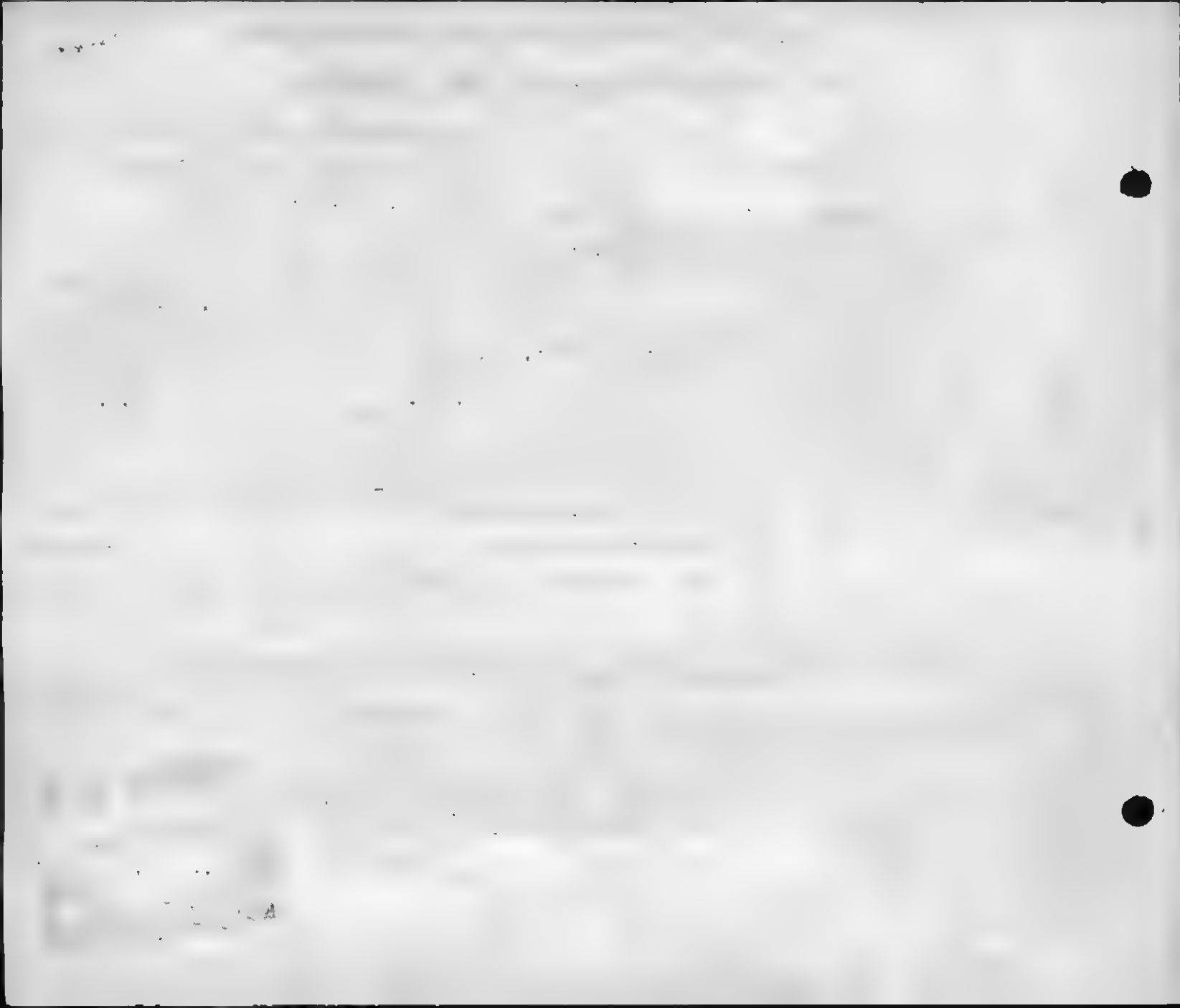
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10581

10579 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Catonsville		LENGTH OF STAY (in this place) 2 1/2 years		CITY (If outside corporate limits, write RURAL and give nearest town) OR Baltimore 22		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital				STREET ADDRESS (If rural give location) 43 Lombardy Drive			
3. NAME OF DECEASED (Type or Print) Carrie Ralston				4. DATE OF DEATH Nov. 14, 1955			
5. SEX F		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH 1897 Oct. 11, 1895	
9. AGE last birthday 58		10. AGE last birthday 58		11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME George Jones				14. MOTHER'S MAIDEN NAME Charlotte Sommerfield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No.				16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Records-Spring Grove State Hospital	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.1 IMMEDIATE CAUSE (A) Acute cardiac failure						10 minutes	
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic cardiovascular disease						years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Huntington's chorea; decubitus necroses							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10/1 , 19 53 , to 11/14 , 19 55 , that I last saw the deceased alive on 12/11 , 19 55 , and that death occurred at 10 A. M., from the causes and on the date stated above. SIGNATURE J. Dyne Williams M.D. ADDRESS (Street, city, town, state) Spring Grove State Hosp., Balt. DATE SIGNED 11/14/55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Nov. 17, 1955		NAME OF CEMETERY OR CREMATORY Meadow Ridge Memorial Park		LOCATION (City, town, or county) (State) Dorsey, Md.	
24. REC'D BY REGISTRAR NOV 16 1955		REGISTRAR'S SIGNATURE Victor E. Harry		25. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home		ADDRESS 2112 Dundalk Ave.	



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VS 153C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

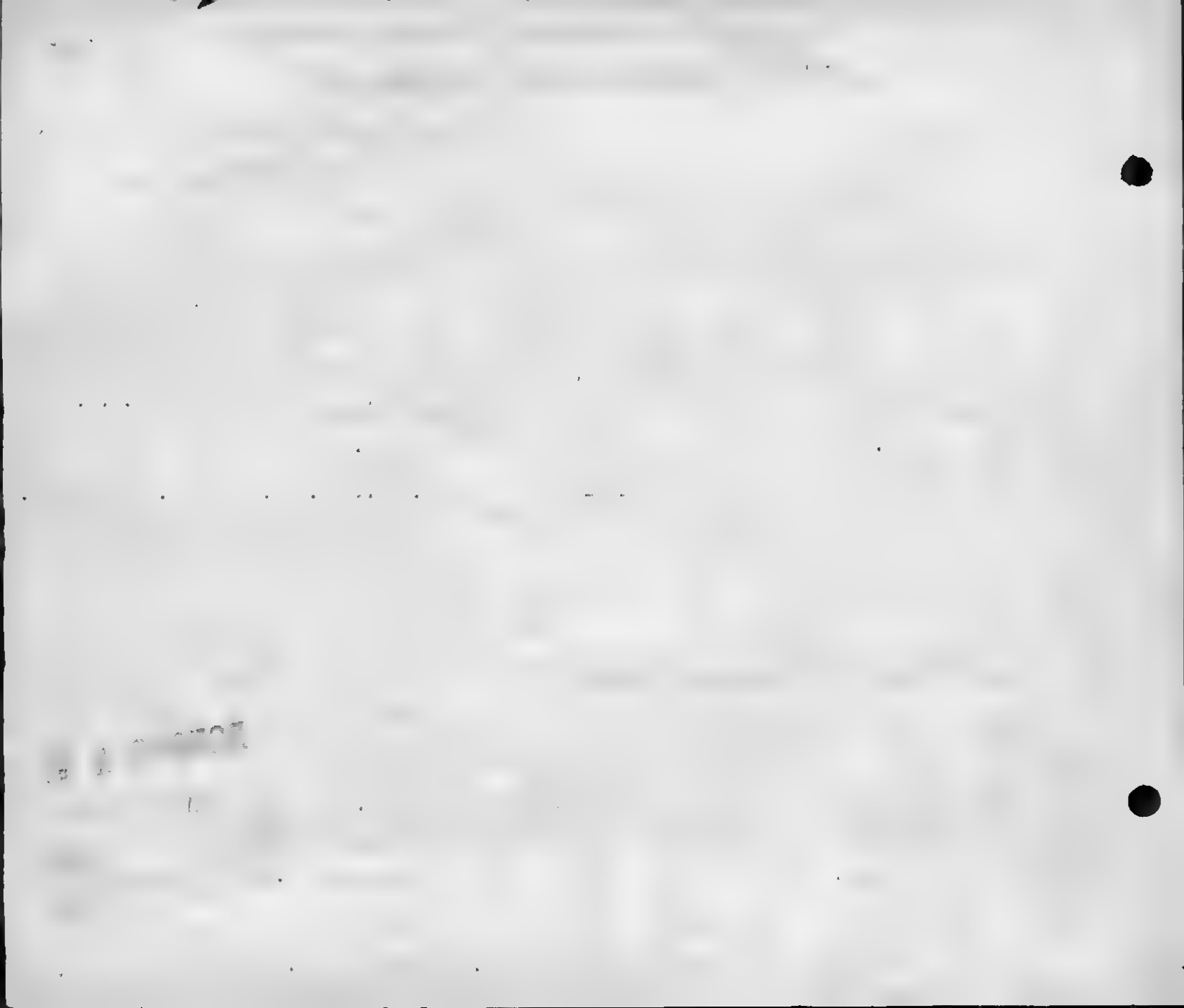
10580

CERTIFICATE OF DEATH

10582

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
* TOWN <u>Fort Howard</u>		<u>6 days</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>930 North Calvert Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>WILLIAM</u> <u>REED</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>November 19</u> <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>7/8/20</u>	9. AGE last birthday <u>35</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Spartanburg, South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elmer W. Ross</u>				14. MOTHER'S MAIDEN NAME <u>Nancy L. Bell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>175-18-1785</u>		17. INFORMANT & ADDRESS <u>Clin. Pec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
18. MEDICAL CERTIFICATION <u>581.0</u> IMMEDIATE CAUSE (A) <u>CIRRHOSIS OF THE LIVER</u>						<u>UNKNOWN</u>	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that <u>VA</u> attended the deceased from <u>Nov. 13, 1955</u> to <u>Nov. 19, 1955</u> , and that death occurred at <u>11:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William B. Vandergrift</u>				ADDRESS (Street, city, town, state) <u>VAH, Fort Howard, Md.</u>		DATE SIGNED <u>11/20/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 25, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>ST. PETERS</u>		LOCATION (City, town, or county) (State) <u>1300 MORELAND AVE</u>	
24. REC'D BY REGISTRAR <u>NOV 29 1955</u>		REGISTRAR'S SIGNATURE <u>Rawson L. Farley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook Blight Inc.</u>		ADDRESS <u>6009 Harford Rd Baltimore 14, Md.</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10466
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10583
Reg. Dist.

No. 42

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balti.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balti.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Lansdowne</u>		<u>2 yrs.</u>		TOWN <u>Lansdowne</u>		<u>27</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>B 48. Trache</u>				STREET ADDRESS (If rural, give location) <u>2129 Saratoga Ave.</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>MERRITT</u>		(Middle) <u>L.</u>		(Last) <u>REEDER JR.</u>		(Month) (Day) (Year) <u>7/12/26 1950</u>	
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>		8. DATE OF BIRTH: <u>Mar 27, 1924</u>	
9. AGE last birthday: <u>35</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>insurance</u>		11. BIRTHPLACE (State or foreign country): <u>Md. - Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Merritt L. Reeder</u>				14. MOTHER'S MAIDEN NAME: <u>Reeder</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY No.: <u>220-01-220</u>		17. INFORMANT & ADDRESS: <u>Lansdowne</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>SOX</u> <u>Entered hospital - Traumatic</u>						<u>3 hrs.</u> <u>3 m.</u> <u>2 m.</u>	
DUE TO							
Antecedent cause(s) (b) <u>Heart</u> <u>Heart</u> <u>Heart</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
stating underlying cause last (c) <u>Spring</u> <u>Heart</u> <u>Heart</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None.</u>							
19a. DATE OF OPERATION: <u>None.</u>				19b. MAJOR FINDING OF OPERATION: <u>None.</u>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>Barber shop</u>		21c. (City or town) (County) <u>Lansdowne</u> <u>Balti.</u>		21d. HOW DID INJURY OCCUR?	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7-15-26</u> <u>5:55</u> <u>PM</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>					
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>J. D. Taylor</u>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>Nov 25 1950</u>			
M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>11-23-55</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>	
DATE REC'D BY LOCAL REGISTRY <u>Nov. 25, 1950</u>		REGISTRAR'S SIGNATURE <u>Dr. Geo. M. Kuffner</u>		24. FUNERAL DIRECTOR <u>Howard H. Hubbard</u> ADDRESS <u>2107 Wilkens Ave</u>			



INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 4-55 10M

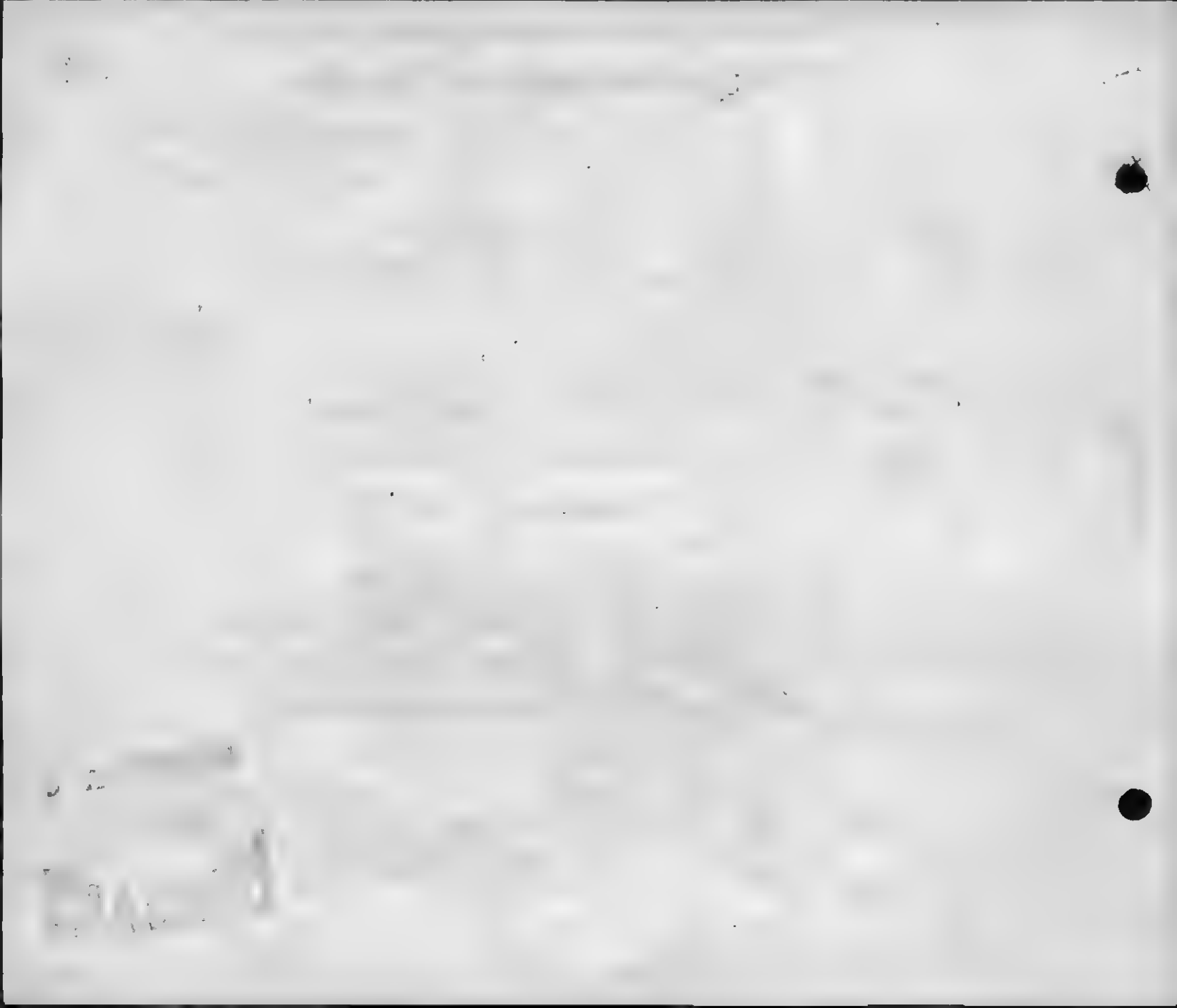
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10581 **CERTIFICATE OF DEATH**

1058

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL or end give nearest town) <u>52 TOWN Catonsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 TOWN Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>104 Delroy Ave</u>				STREET ADDRESS (If rural give location) <u>104 Delroy Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>Anna</u> <u>May</u> <u>Reidt</u>				4. DATE OF DEATH (Month) <u>Nov.</u> (Day) <u>27</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 12, 1899</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> </u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Scranton, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Joseph Paff</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT & ADDRESS <u>Mr. P. Reidt, 104 Delroy Ave.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>200.1 IMMEDIATE CAUSE (A) Cardio-Respiratory failure</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>accident & dehydration</u> DUE TO (C) <u>Intestinal Obstruction & Peritonitis</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>fluid lymphangiocarcinoma</u>							
19a. DATE OF OPERATION <u> </u>		19b. MAJOR FINDINGS OF OPERATION <u>Microscopic lymphangiocarcinoma</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <u> </u>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u> </u>		21c. WHERE DID INJURY OCCUR? (City or town) <u> </u>		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u> </u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u> </u>		21f. HOW DID INJURY OCCUR? <u> </u>			
22. I hereby certify that I attended the deceased from <u>1953</u> , 19....., to <u>27 Nov. 1955</u> , that I last saw the deceased alive on <u>27 Nov. 1955</u> , and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William J. Byrson</u>				ADDRESS (Street, city, town, state) <u>M.D. 4605 Edmondson Ave</u>		DATE SIGNED <u>28 Nov 55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		DATE THEREOF <u>Nov. 30/55</u>		NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		LOCATION (City, town, or county) (State) <u>md</u>	
24. REC'D BY REGISTRAR <u>Nov. 29, 1955</u>		REGISTRAR'S SIGNATURE <u>T. E. Garvey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harry A. Witzke</u>		ADDRESS <u>4101 Edmondson Ave</u>	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detailed for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

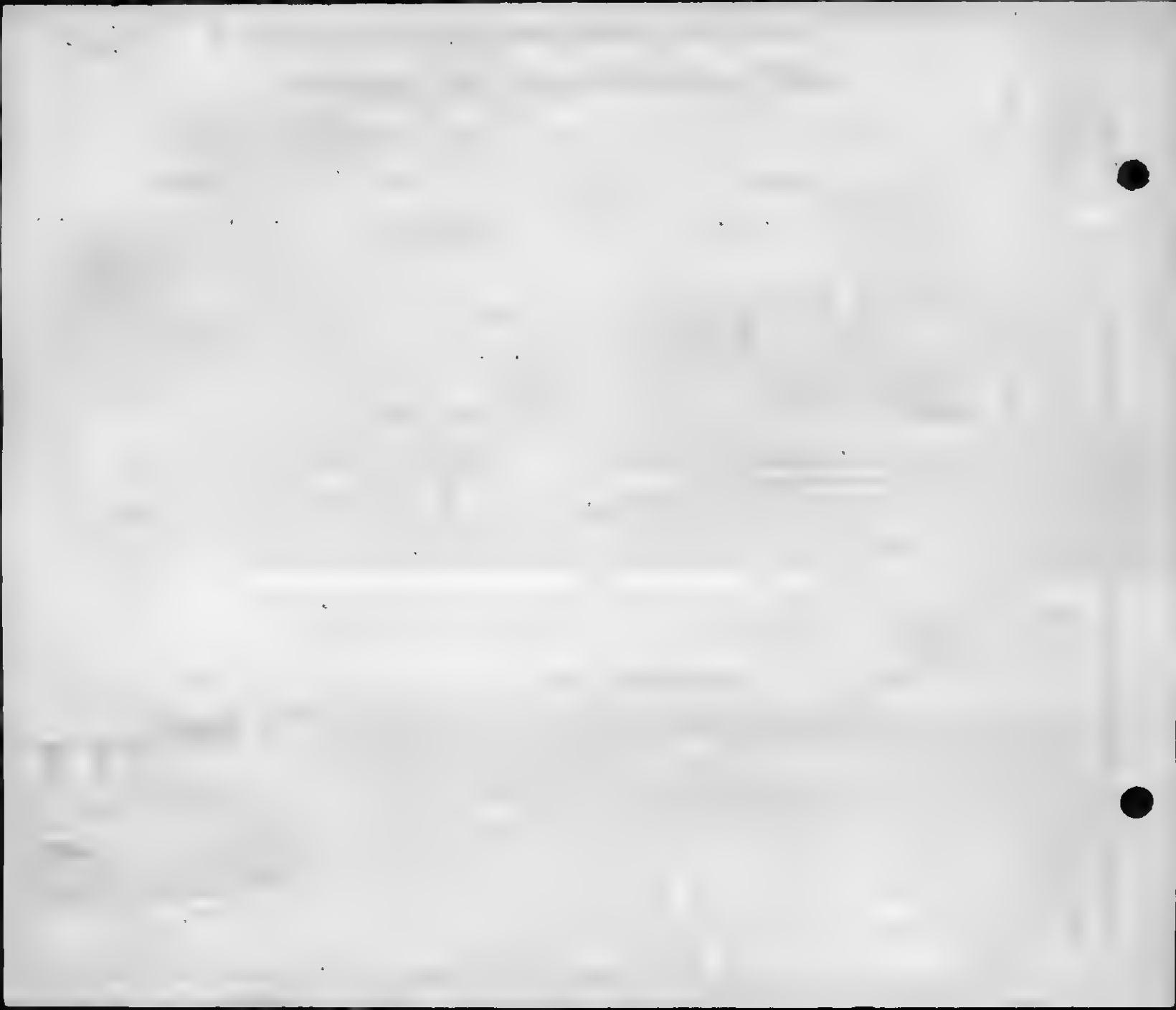
 Form 2, Rev. 11/25/55
 10582

CERTIFICATE OF DEATH

10585

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore County</u> CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cockeysville, Md.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1536 Monroe St., N.W.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED <input checked="" type="checkbox"/> STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cockeysville, Md.</u> STREET ADDRESS (If rural give location) <u>1536 Monroe St., N.W.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Lydelle</u> (Middle) <u>Francina</u> (Last) <u>Reynolds</u>		4. DATE OF DEATH (Month) <u>II</u> (Day) <u>15th</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Dec. 27, 1872</u>
9. AGE last birthday <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>62</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stenographer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>United States</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Christian J. Conradt</u>		14. MOTHER'S MAIDEN NAME <u>Geneva Jane Suter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) (C) 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>10:00 A.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 16, 1955</u> to <u>Nov 15, 1955</u> , that I last saw the deceased alive on <u>Nov 15, 1955</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Walter T. Lees</u> M.D. <u>Cockeysville, Md.</u> DATE SIGNED <u>15 Nov. 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-17-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
24. REC'D BY REGISTRAR <u>A. H. Hedrich</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc.</u> ADDRESS <u>1217 St. Paul St., Balto.</u>	



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10586

10583 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>RODGERS FORGE</u>				TOWN <u>RODGERS FORGE</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6819 BLENHEIM RD</u>				STREET ADDRESS (if rural give location) <u>6819 BLENHEIM RD.</u>			
3. NAME OF DECEASED (Type or Print) <u>JOHN PETER RILEY</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>NOV 10 1955</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>JAN 2 1925</u>	
9. AGE last birthday <u>30</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PURCHASER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NESSCO Co</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS EDWARD RILEY</u>				14. MOTHER'S MAIDEN NAME <u>ANNE PRENGER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>1</u>		16. SOCIAL SECURITY NO. <u>218-22-8881</u>		17. INFORMANT & ADDRESS <u>MARIAN K RILEY SAME</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
416X IMMEDIATE CAUSE (A) <u>RHEUMATIC CARDIOVASCULAR</u>						25 yrs	
ANTECEDENT CAUSE(S) DUE TO (B) <u>DISEASE</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>8:55</u>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug</u> , 19 <u>55</u> , to <u>Nov 10 1955</u> , that I last saw the deceased alive on <u>Nov 10 1955</u> , and that death occurred at <u>8:55 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Frederick J. Vollmer</u>				ADDRESS (Street, city, town, state) <u>6100 York Rd. Balto-12</u>			
DATE SIGNED <u>11-11-55</u>							
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>NOV 14/55</u>		NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		LOCATION (City, town, or county) <u>BALTO. MD</u>	
24. REC'D BY REGISTRAR <u>Nov. 14 1955</u>		REGISTRAR'S SIGNATURE <u>Mabel Gray</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. H. Jenkins</u>		ADDRESS <u>4905 YORK RD</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: This law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The bottom copy may be retained by the hospital or attending physician.

VS MHC 1-55 10M



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10584

CERTIFICATE OF DEATH

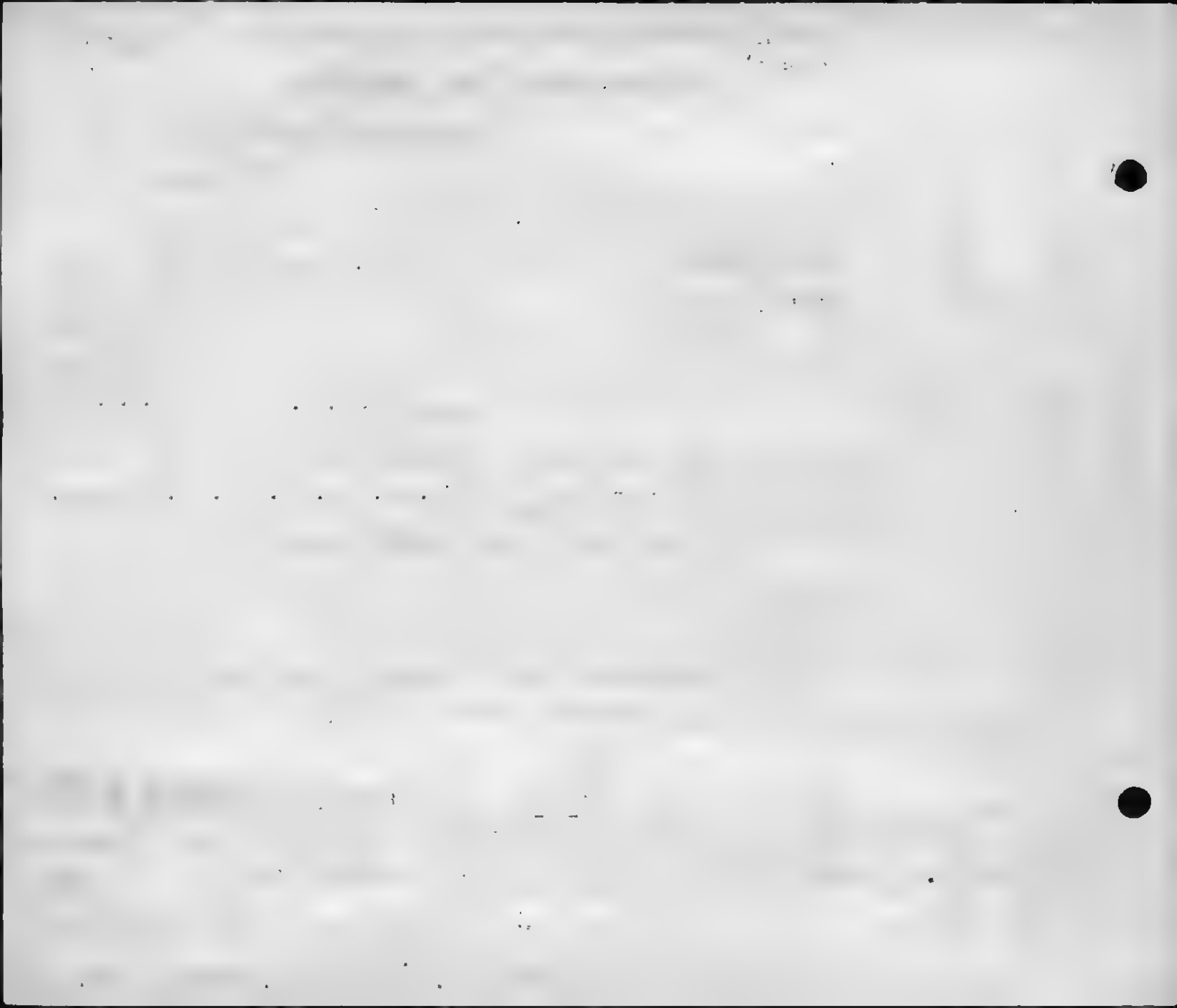
10587

44

Item 1, 191-1088 11-2-55 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY BALTIMORE		STATE MARYLAND		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN FORT HOWARD		20 hrs; 20 min.		TOWN BALTIMORE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL				STREET ADDRESS (If rural give location) 202 N. STRICKER STREET			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
BENNIE ROBBINS				NOVEMBER 1, 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
MALE	COLORED	MARRIED	11-9-13	41 yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY CHEMICAL PLANT		11. BIRTHPLACE (State or foreign country) ROCKY MOUNT, N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GROGIE ROBBINS				14. MOTHER'S MAIDEN NAME MAGGIE FREEMAN			
15. WAS/DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) YES		16. SOCIAL SECURITY NO. 215-10-5842		17. INFORMANT & ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
4 + X		IMMEDIATE CAUSE (A) HYPERTENSIVE CARDIOVASCULAR DISEASE				5 YEARS	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE		(B)					
STATING UNDERLYING CAUSE LAST.		DUE TO (C)					
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10:40 AM to 7:00 AM, and that death occurred at 7:00 AM, from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
JOHN A. SURMONTE		VAH, Fort Howard, Maryland		11-1-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
BURIAL		BALTIMORE NATIONAL CEMETERY		BALTIMORE, MARYLAND			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
DATE Nov. 2, 1955		Dawson L. Fisher		ISAIAH L. BROWN & SON,			
				108 W. Montgomery St., Baltimore, Md.			



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and properly filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10588

10457 CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>BALTO.</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>BALTO.</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>DUNDALK 22</u>	<u>34</u>	TOWN <u>DUNDALK 22</u>	<u>53</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>1818 PARTSHIP RD</u>		<u>1818 PARTSHIP RD</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) (Middle) (Last) <u>ANNIE GLADFELTER ROGERS</u>		(Month) (Day) (Year) <u>11-3-1953</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>FEM.</u>	<u>W.</u>	<u>MARRIED</u>	<u>25 APRIL 1889</u>
9. AGE last birthday		10. IF UNDER 1 YEAR	
<u>66</u> yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<u>HOUSEWIFE</u>			
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>PENNSA</u>		<u>U.S.A.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>ORESTUS GLADFELTER</u>		<u>SARAH BACKERT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
<u>NO</u>		<u>213-07-6232B</u>	
17. INFORMANT & ADDRESS			
<u>E. P. CURTIN 1600 GRAY PL. DUNDALK</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A)		<u>Cerebral Hemorrhage</u>	
ANTECEDENT CAUSE(S) DUE TO (B)		<u>Arteriosclerosis</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)		<u>Diabetes</u>	
		<u>Myocarditis, chronic</u>	
19. DATE OF OPERATION		20. AUTOPSY	
<u>NO</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
<input type="checkbox"/>		<input type="checkbox"/>	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. HOW DID INJURY OCCUR?	
<u>NO</u>		<u>NO</u>	
22. I hereby certify that I attended the deceased from <u>NOV 3</u>, 19<u>53</u>, to <u>NOV 3</u>, 19<u>53</u>, that I last saw the deceased alive on <u>NOV 3</u>, 19<u>53</u>, and that death occurred at <u>1:10 P.M.</u> from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>Edward H. Andrew</u>		<u>NOV 14 1953</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		24. REC'D BY REGISTRAR	
<u>BURIAL</u>		<u>NOV 7-1953</u>	
DATE THEREOF		REGISTRAR'S SIGNATURE	
<u>11-7-55</u>		<u>William M. Kelly</u>	
NAME OF CEMETERY OR CREMATORY		25. FUNERAL DIRECTOR'S SIGNATURE	
<u>PAK LAWN</u>		<u>George Bradley, Dundalk, Md</u>	
LOCATION (City, town, or county) (State)		ADDRESS	
<u>BALTO., CO., MD.</u>			



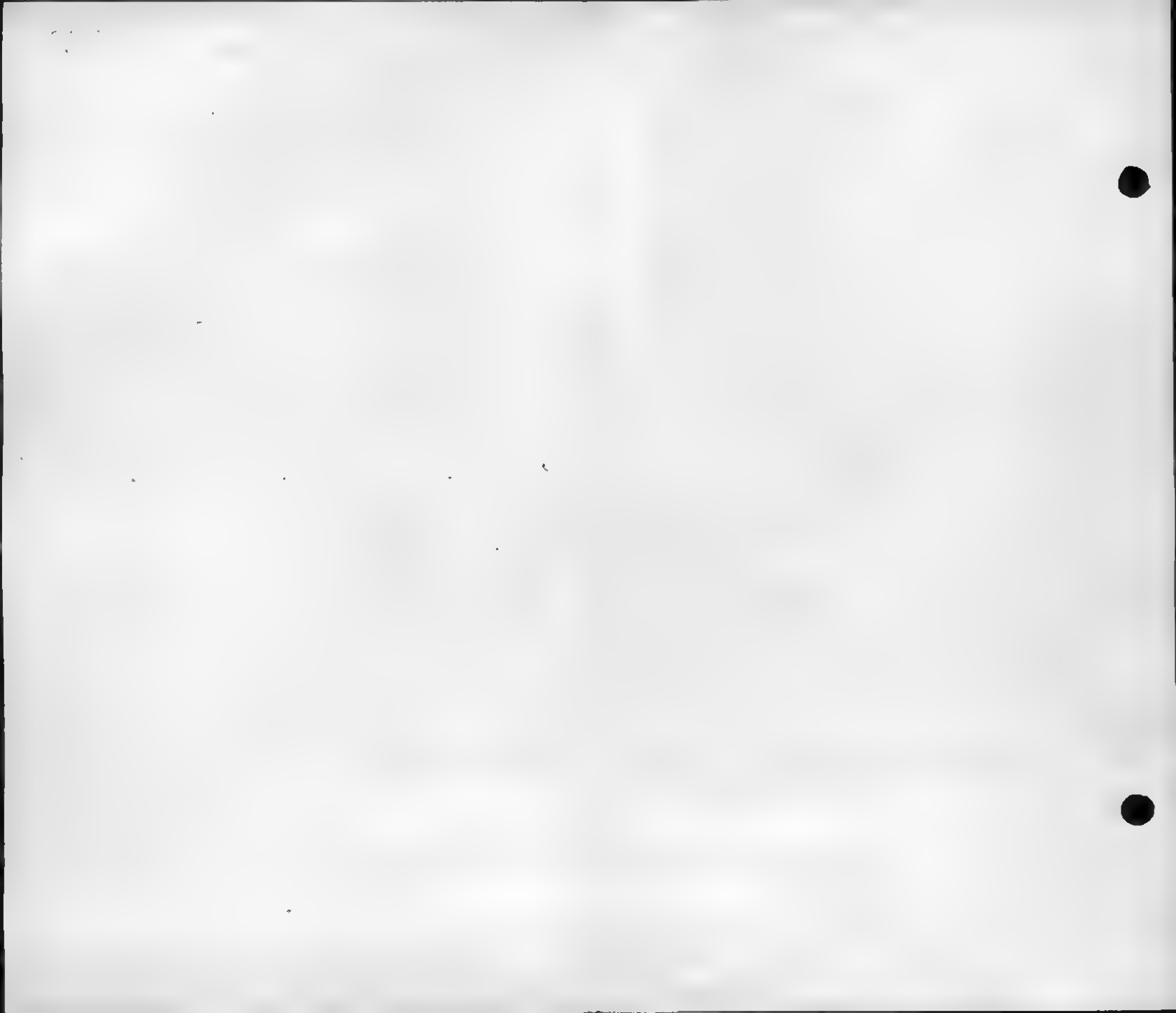
10585 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>X</u>		LENGTH OF STAY (in this place) <u>2110 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>		STREET ADDRESS <u>115 Willard St.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS <u>115 Willard St.</u>			
3. NAME OF DECEASED: (First) <u>Charles</u> (Middle) <u>Henry</u> (Last) <u>ROTAN JR</u>				4. DATE (Month) <u>11</u> (Day) <u>21</u> (Year) <u>1955</u>			
5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>				8. DATE OF BIRTH: <u>10-13-1928</u> 9. AGE last birthday <u>27</u> yrs <u>1</u> Months <u>8</u> Days <u>0</u> Hours <u>0</u> Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Clerk</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-1373</u>		17. INFORMANT & ADDRESS: <u>Mt. Wilson State Hosp. Hosp. Records, Mt. Wilson, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>002X</u>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> gt work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10</u> , 19 <u>55</u> , to <u>11-21</u> , 19 <u>55</u> ; that I last saw the deceased alive on <u>11-21</u> , 19 <u>55</u> , and that death occurred at <u>4</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>William Newman</u>		ADDRESS <u>M.D.Mt. Wilson, Md.</u>		DATE SIGNED <u>11-21-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov 24</u>		NAME OF CEMETERY OR CREMATORY <u>North Mt. Pleasant</u>		LOCATION (City, town, or county) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11-22-55</u>		REGISTRAR'S SIGNATURE <u>A.W. Hedrich</u>		24. FUNERAL DIRECTOR <u>W.H.C. B.M. Walters</u>		ADDRESS <u>Strickland</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



10586

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (if outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pikesville</u>	LENGTH OF STAY (in this place) <u>16 yrs.</u>	CITY (if outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pikesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>205 Clarendon</u>		STREET ADDRESS (if rural give location) <u>205 Clarendon</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Virgie Belle Royer</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>11</u> <u>24</u> <u>1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>3 Sep. 1866</u>
9. AGE last birthday <u>89</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>none</u>	
11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John Daniel Conard</u>		14. MOTHER'S MAIDEN NAME: <u>Olivia Fout</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT'S ADDRESS: <u>Mrs Henry Roschen 205 Clarendon Pikesville 8 Md</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
330X IMMEDIATE CAUSE (A) <u>Subarachnoid Hemorrhage</u>			<u>6 days.</u>
ANTECEDENT CAUSE (B) <u>Hypertension</u>			<u>9 yrs.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>fractures both left femur</u>			<u>3 + 4 yrs.</u>
19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>Nov, 1946</u> to <u>24 Nov, 1955</u> , that I last saw the deceased alive on <u>23 Nov., 1955</u> ; and that death occurred at <u>1205 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Paul H Royce</u>		ADDRESS <u>Pikesville 8 Md.</u> DATE SIGNED <u>24 Nov 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	
<u>Burial</u>		<u>Nov 26 1955</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>St. Oliver</u>		<u>Fredrick Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>Nov-26-1955</u>		<u>North A. Newell</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Frank H. Newell</u>		<u>Pikesville, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S.

100

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10591

10587

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X TOWN Notch Cliff near Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN Notch Cliff near Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Villa Maria Glenarm Rd.</u>		STREET ADDRESS (If rural, give location) <u>Glenarm Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Sister Mary Theobald Rudee</u>		4. DATE OF DEATH (Month) <u>Nov</u> (Day) <u>23</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Dec. 27, 1865</u>
9. AGE last birthday <u>89</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Rudee</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Polneis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>RE-101025</u>	
17. INFORMANT AND ADDRESS <u>Sr. Mary Clara Notch Cliff Md</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
1. <u>3X</u> Immediate cause (a) <u>Metastatic Carcinoma to Lungs</u>		<u>6 wks</u>	
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Carcinoma of Sigmoid</u>		<u>10 yrs</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR? While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	

22. I hereby certify that I attended the deceased from June 10, 1952, to Nov. 23, 1955, that I last saw the deceased

alive on Nov. 23, 1955, and that death occurred at 5:00 A. m., from the causes and on the date stated above.

SIGNATURE Charles J. Conkling (Degree or title) ADDRESS 7501 YORK RD. DATE SIGNED 11/23/55

23. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>11-25-55</u>	NAME OF CEMETERY OR CREMATORY <u>VILLA MARIA CEM.</u>	LOCATION (City, town, or county) (State) <u>NOTCH CLIFF NR TOWSON, MD</u>
DATE REC'D BY LOCAL REG. <u>11-25-55</u>	REGISTRAR'S SIGNATURE <u>Charles J. Conkling</u>	24. FUNERAL DIRECTOR <u>Charles J. Conkling</u>	ADDRESS <u>9015 CONKLING ST. BALTA, 24, MD</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10592

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10588

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
50 <u>3521 Meadowside Rd.</u>				<u>3521 Meadowside Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>HERMAN H. RUSS</u>				<u>Nov. 21, 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Mln.	
<u>male</u>	<u>white</u>	<u>single</u>	<u>Aug. 28, 1896</u>	<u>59</u> yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		
<u>Punch Press Operator - Can Co.</u>					<u>Md.</u>		
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Carl Russ</u>				<u>Wilhemena Klender</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>no</u>				<u>215 - 05 - 5480</u>		<u>Mr. Charles Russ - 419 Lambeth Rd.</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE							
(A) DUE TO <u>Coronary Thrombosis</u>							
ANTECEDENT CAUSE (S):							
(B) DUE TO <u>arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>53</u> , to <u>Nov 21</u> , 19 <u>55</u> that I last saw the deceased alive on <u>Nov 21</u> , 19 <u>55</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>11/22/55</u>			
M. D. <u>9710 Liberty Hts</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/25/55</u>		<u>Mt. Olive Cem.</u>		<u>Randallstown, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>25 - 55</u>		<u>[Signature]</u>		<u>Thm. J. Pickner & Sons - Balto 17 Md</u>			

MARGIN RESERVED FOR BINDING

VS. A15 - 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. This correct age is especially important. Physicians: please write the cause of death clearly and legibly.

11/11/11

CERTIFICATE OF DEATH

Reg. Dist. No.

10593

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Baltimore	STATE	Md.
CITY (If outside corporate limits, write RURAL and give nearest town)	Overlea	COUNTY	Balto.
HOSPITAL OR INSTITUTION OR STREET ADDRESS	6703 Linden Ave.	CITY (If outside corporate limits, write RURAL and give nearest town)	Overlea
		STREET ADDRESS (If rural give location)	6703 Linden Ave.

3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First)	(Middle)	(Month)	(Day)
(Type or Print)	EDWARD W.	NOV.	15
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
male	white	married	Nov. 25, 1869
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:	
retired tailor		self-employed	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
unknown		unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:	
no		no	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
Mrs. Sophie Fryer, dght, above			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death
443X Immediate cause		2 days
(a) Pulmonary Edema		
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		10 yrs.
(b) Cardio-Vascular Hypertensive Disease		10 yrs.
(c) Arteriosclerosis		

11. OTHER SIGNIFICANT CONDITIONS		12. CITIZEN OF WHAT COUNTRY?	
Conditions contributing to the death but not related to the disease or condition causing death.		U.S.A.	
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY ?			
Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
SUICIDE		(CITY OR TOWN)	
HOMICIDE		(COUNTY)	
(STATE)			
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED	
OF INJURY		While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
		HOW DID INJURY OCCUR ?	

22. I hereby certify that I attended the deceased from JAN., 2, 1955, to NOV., 15, 1955, that I last saw the deceased alive on NOV., 14, 1955, and that death occurred at 6:00 A.M., from the causes and on the date stated above.			
SIGNATURE		ADDRESS	
Michael J. Dausch		4636 Belair Road	
DATE SIGNED		11/15/55	
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
Burial		Oak Hill Cemetery	
DATE THEREOF		LOCATION (City, town, or county)	
Nov. 18, 1955		Baltimore, Md.	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
11/16/55 A.W. Hedrick		Schimunek Funeral Home, Inc.	
		ADDRESS	
		2601-3-5 E. Madison St.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

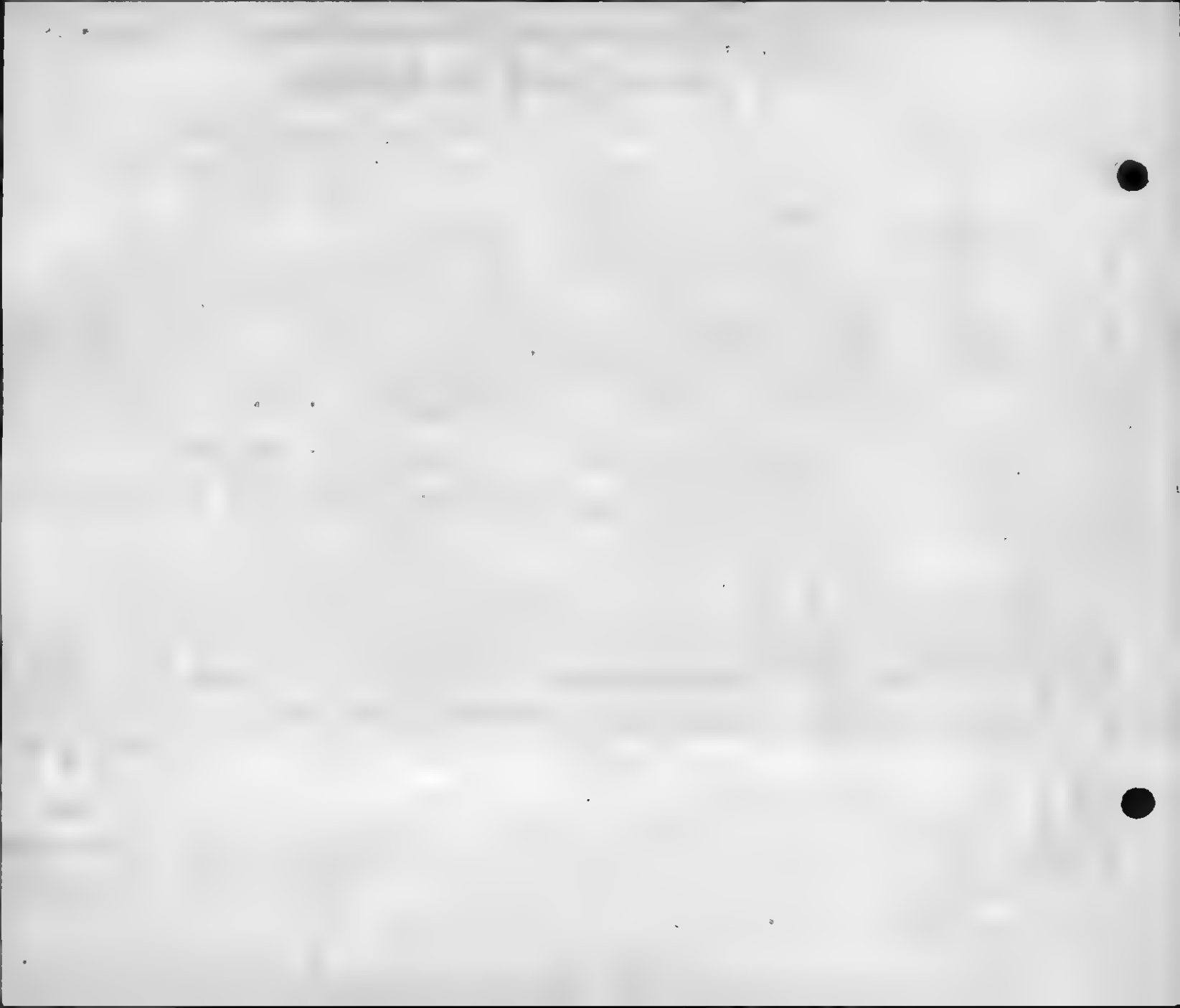
10594

10590

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Dundalk</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1812 Portship Road</u>				STREET ADDRESS (If rural give location) <u>1812 Portship Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Lydia Jane Safreed</u>				<u>Nov. 5, 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>Dec. 14, 1879</u>	<u>75</u> yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Parkersburg, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Charles Jones</u>				14. MOTHER'S MAIDEN NAME <u>Mellie A. Workman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes; no or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Gladys Lewis 2 Warren Rd. (21</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>48 hours</u>			
<u>1451X</u> IMMEDIATE CAUSE (A) <u>Dissecting Aneurysm</u>				<u>20 yrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis HS</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-3</u>, 19<u>55</u>, to <u>11-5</u>, 19<u>55</u>, that I last saw the deceased alive on <u>11-5</u>, 19<u>55</u>, and that death occurred at <u>10:57</u> p.m. from the causes and on the date stated above.							
SIGNATURE <u>Jo. H. E. Collins</u>		M.D. <u>Baet 2-2</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>11-7-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 9, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore Co. Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Lawson L. Farley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc.</u>		ADDRESS <u>1217 St. Paul St.</u>	
DATE <u>Nov. 7, 1955</u>							



10591 CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH:

COUNTY

Balto.

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

54

TOWN

Essey

HOSPITAL OR INSTITUTE OR STREET ADDRESS

Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md.

COUNTY

Balto.

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN

Essey

(Eastern Prince)

STREET ADDRESS

10 Platan Road

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

John Sidney Sale

4. DATE

(Month)

(Day)

(Year)

OF DEATH:

11/19

1955

5. SEX:

M.

6. COLOR OR RACE:

W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)

Married

8. DATE OF BIRTH:

July 24-1908

9. AGE last birthday:

47

IF UNDER 1 YEAR

Months Days Hours Min.

3 25

10a. USUAL OCCUPATION (Give kind of work done during most of working life, (Type or Print))

Exp. Guard

10b. KIND OF BUSINESS OR INDUSTRY:

Glenn Martin Co.

11. BIRTHPLACE (State or foreign country):

Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

Samuel J. Sale

14. MOTHER'S MAIDEN NAME:

Elsie Houseman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

175-01-3310

17. INFORMANT & ADDRESS:

Evelyn M. Sale

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1

Immediate cause

(a) DUE TO

Coronary Occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

Coronary Insufficiency

(c)

INTERVAL BETWEEN ONSET AND DEATH

1 year

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/14, 1954, to 11/17, 1955, that I last saw the deceased alive on 11/17, 1955, and that death occurred at 4:40 a.m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

11/21/55

V. M. Hensch

Wm. J. Connelly

Essey

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No. 491...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN <u>Fort Howard</u>		<u>11 Days</u>		TOWN <u>Ellicott City</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>RFD #2</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>EDWARD B. SAUNDERS</u>				<u>November 20 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		8. DATE OF BIRTH: <u>4-23-77</u>		9. AGE last birthday (If under 1 year) (Months) (Days) (Hours) (Min.)	
		7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>Married</u>		<u>12-20-55</u>		<u>18 77 78</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>				10B. KIND OF BUSINESS OR INDUSTRY:			
11. BIRTHPLACE (State or foreign country): <u>St. Paul, Minnesota</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME: <u>Frank Saunders</u>				14. MOTHER'S MAIDEN NAME: <u>Ann Noble</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes P.I.</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Maryland</u>							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>HEMORRHAGIC CYSTITIS</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE (S) <u>260X</u>				DUE TO <u>BENIGN HYPERTROPHIC PROSTATE</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) DUE TO			
				(C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>DIABETES MELLITUS</u>							
<u>GENERALIZED ARTERIOSCLEROSIS</u>							
19A. DATE OF OPERATION: <u>2</u>							
19B. MAJOR FINDINGS OF OPERATION							
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 9, 1955</u> , to <u>Nov. 20, 1955</u> , and that death occurred at <u>1:40 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>James J. Nolan</u>				ADDRESS <u>M. D. VAH, FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>11-21-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>11-25-55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>	
						LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11-22-1955</u>		REGISTRAR'S SIGNATURE <u>John D. ...</u>		24. FUNERAL DIRECTOR <u>Frank C. Higinbotham</u>		ADDRESS <u>Ellicott City Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

10597

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10593 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Town Notch Cliff near Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Town Notch Cliff near Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Villa Maria Glenary Rd</u>		STREET ADDRESS (If rural, give location) <u>Glenary Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Sister Mary Jane Schied</u>		4. DATE OF DEATH (Month) <u>13</u> (Day) <u>19</u> (Year) <u>55</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 6 1880</u>
9. AGE last birthday <u>75</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Blackport N.Y.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Schied</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Heller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Sr. Mary Clara, Notch Cliff, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause

(a)---

Coronary Occlusion

INTERVAL BETWEEN ONSET AND DEATH

8 weeks

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)---

Myocardial Degeneration

8 weeks

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from April 3, 1955, to Nov. 13, 1955, that I last saw the deceased

alive on November 8, 1955, and that death occurred at 4:00 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
BURIAL	11-15-55	VILLA MARIA CEM.	NOTCH CLIFF NR TOWSON, MD.	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
11/14/55	W. W. Hedrick	Charles S. Zuber	901 S. CONKLING ST. BALTO., MD.	

MARGIN NERVE FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3.

201



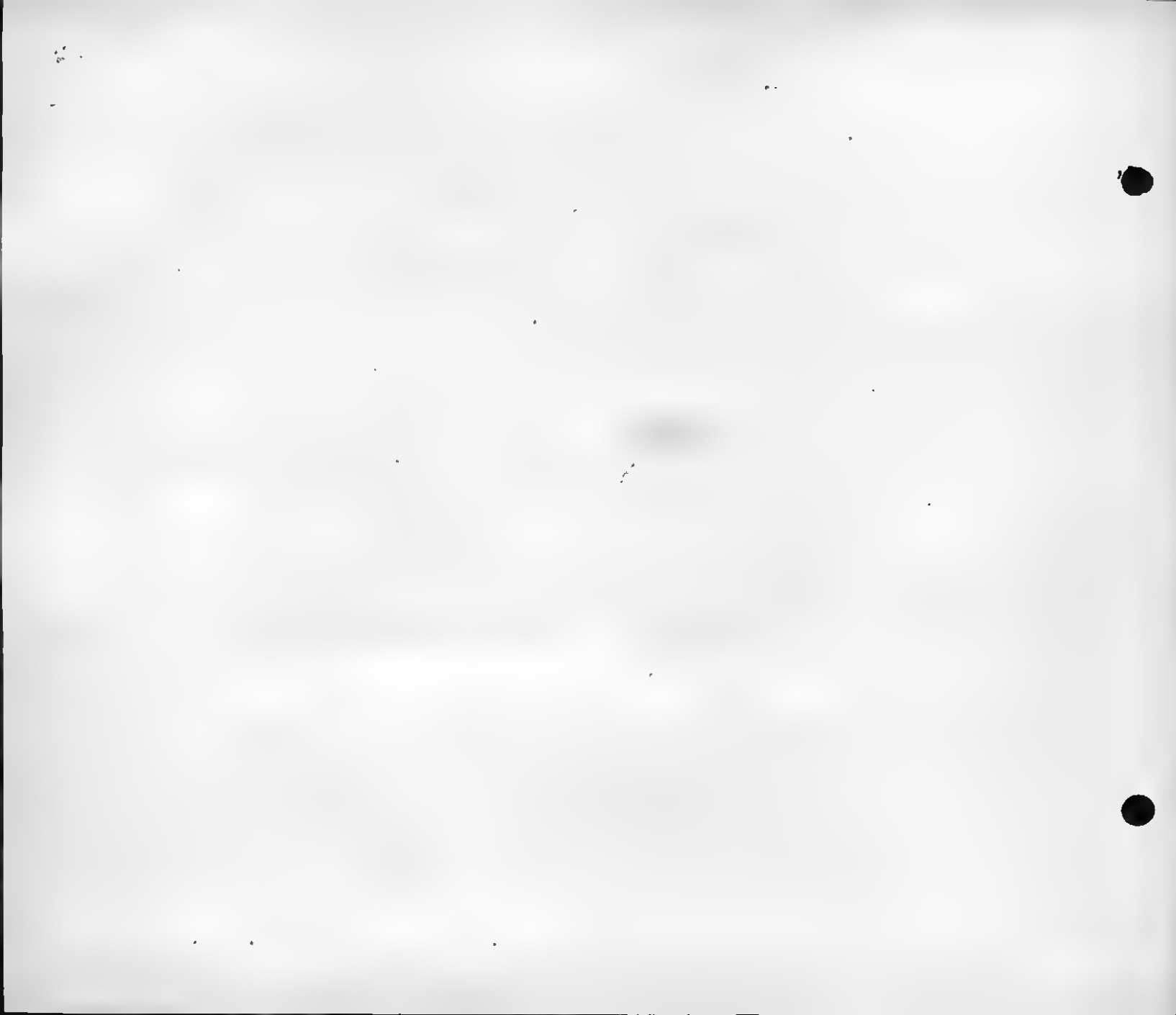
10594 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Balto. MARYLAND		STATE Md. COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 401 Allview Court		STREET ADDRESS (If rural give location) 401 Allview Court	
3. NAME OF DECEASED: (First) (Middle) (Last) ELsie DUvall SCHLICKENMAIER		4. DATE (Month) (Day) (Year) OF DEATH: Nov. 17, 1955	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: Aug. 17, 1875
9. AGE last birthday 80 yrs		10. BIRTHPLACE (State or foreign country): Penna.	
11. BIRTHPLACE (State or foreign country): Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Conrad Duerr		14. MOTHER'S MAIDEN NAME: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT & ADDRESS: Mrs. H. Gallatin-401 Allview Ct., Ctnsvl			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage			15 min
ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			?
(C) Cerebral Hemorrhage			7 wks
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from July 20, 1948, to 11-17, 1955, that I last saw the deceased alive on Nov 15, 1955, and that death occurred at 11 P. M. from the causes and on the date stated above.			
SIGNATURE Earl Pass M.D.		ADDRESS 4001 Wehner Ave	
		DATE SIGNED 11-19-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 11/21/55	
		NAME OF CEMETERY OR CREMATORY Western Cem.	
		LOCATION (City, town, or county) (State) Balto., Md.	
DATE REC'D BY LOCAL REGISTRAR November 19, 1955		REGISTRAR'S SIGNATURE R.W.	
		24. FUNERAL DIRECTOR J. J. Schenker & Sons	
		ADDRESS Baltimore, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

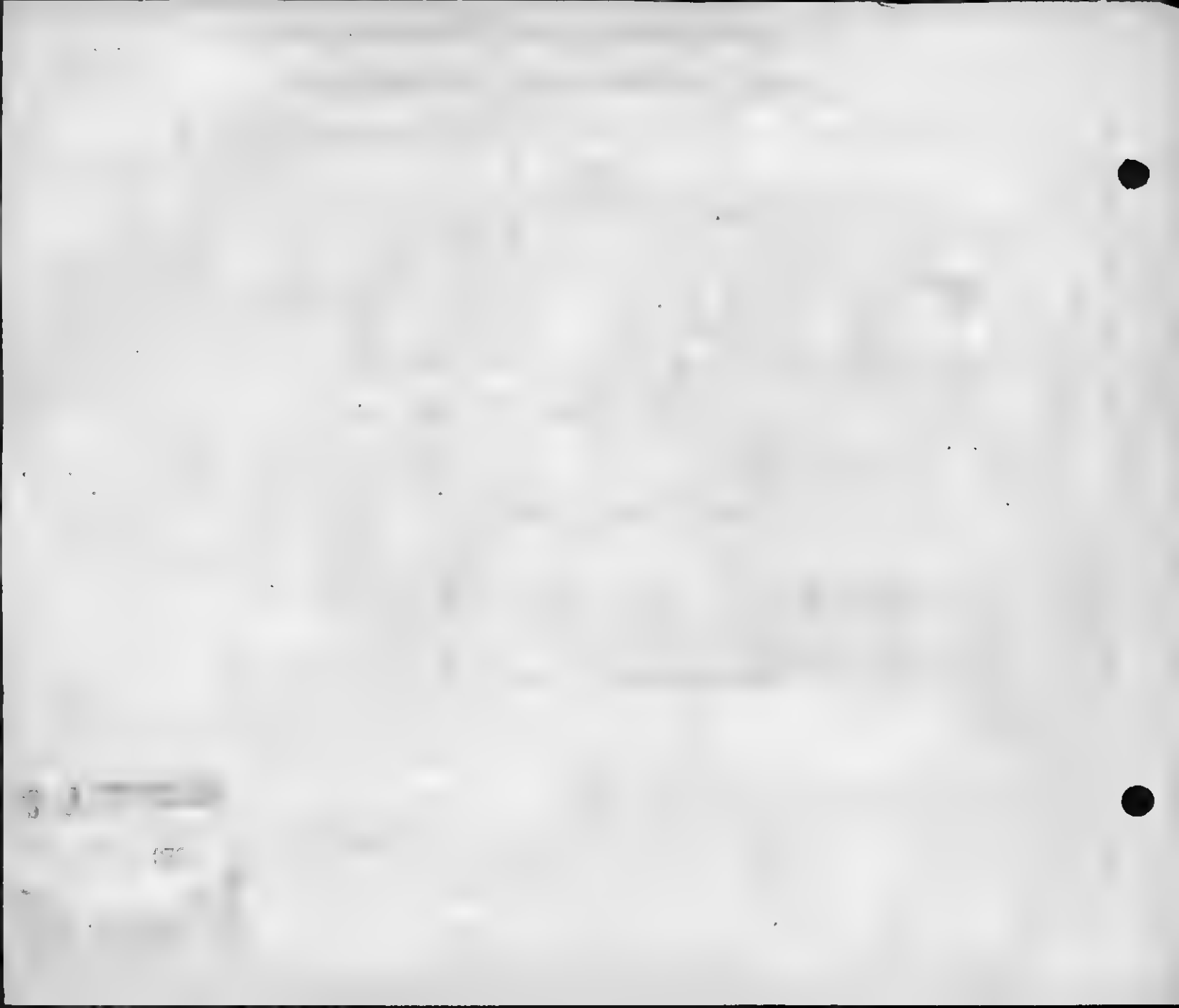
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10595 CERTIFICATE OF DEATH

10599

Reg. Dist. No. 40

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Glen Arm.</u>				TOWN <u>Glen Arm</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Road</u>				STREET ADDRESS (If rural give location) <u>Harford Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Miss</u> (Middle) <u>Annie</u> (Last) <u>E. Schneider</u>				(Month) <u>November</u> (Day) <u>29th</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>female</u>	<u>white</u>	<u>single</u>	<u>July 11, 1881</u>	<u>74</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farm Worker</u>		<u>Dairy</u>		<u>Baltimore Co., Maryland</u>		<u>USA</u>	
13. FATHER'S NAME <u>Mr. Joseph Schneider</u>				14. MOTHER'S MAIDEN NAME <u>Mary Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Glen Arm, Md. Mrs. Hattie Neuhauser, Harford Rd.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>420.0</u> IMMEDIATE CAUSE (A) <u>congestive heart failure</u>				<u>if mos.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerotic heart disease</u>				<u>24 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/26</u> , 19 <u>55</u> , to <u>11/29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/28</u> , 19 <u>55</u> , and that death occurred at <u>3:00</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Leonard J. Ruck</u> M.D.				ADDRESS (Street, city, town, state) <u>5305 Harford Road #14</u> DATE SIGNED <u>Dec 1 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 1, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mononite Cemetery</u>		LOCATION (City, town, or county) (State) <u>Glen Arm, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Dr. Walter Hammett</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>			
DATE							



10596

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
X <u>Pikesville</u>	<u>5 days</u>	<u>Baltimore City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>114 Waldron Ave.</u>		<u>4004 Primrose Ave.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Ida</u>	(Middle) <u>C.</u>	(Last) <u>Schneider</u>	(Month) <u>Nov.</u> (Day) <u>8</u> (Year) <u>1955</u>
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>June 25, 1877</u>
		9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>none</u>	11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>
13. FATHER'S NAME: <u>George H. Purcell</u>		14. MOTHER'S MAIDEN NAME: <u>Mary E. White</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Charles Schneider, 4004 Primrose Ave.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Carcinoma of Uterus</u>			<u>3 yrs.</u>
ANTECEDENT CAUSE (B) <u>Broncho-pneumonia</u>			<u>3 days</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) <u>Anterior Sclerotic Heart Disease</u>			<u>5 yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>None</u>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept. 23, 1952</u> , to <u>Nov. 8, 1955</u> , that I last saw the deceased alive on <u>Nov. 7, 1955</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Paul L. Chambers</u>		ADDRESS <u>4108 Liberty Hts. Balto.</u> DATE SIGNED <u>11/9/55</u>	
M.D. <u>7- md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Nov. 10, 55</u>	<u>Loudon Park</u>	<u>Frederick Rd. Balto, Md.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Nov. 10, 1955</u>	<u>Carolyn A. Newell</u>	<u>Frank H. Newell</u>	<u>Pikesville, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



10597 CERTIFICATE OF DEATH

10601

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL, and give nearest town)			
55 TOWN Rural: Towson				TOWN Rock Hall		141-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Eudowood Sanatorium Towson 4, Maryland				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
Walter T. Scoon				11 29 55			
5. SEX: M		6. COLOR OR RACE: W		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: 9 18 92	
				63 yrs.		9. AGE last birthday: 63	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired:		10b. KIND OF BUSINESS OR INDUSTRY: Sea Food Dealer		11. BIRTHPLACE (State or foreign country): Rock Hall, Md.		12. CITIZEN OF WHAT COUNTRY: U.S.	
13. FATHER'S NAME: John T. Scoon				14. MOTHER'S MAIDEN NAME: Ester Jackson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) no		16. SOCIAL SECURITY No.: none		17. INFORMANT & ADDRESS: Personal History Hospital Records, Eudowood Sanatorium			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between			
max Immediate cause (a) Pulmonary Tuberculosis				And Death 57 3/4			
Antecedent causes (s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO							
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: none				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		INJURY					
HOMICIDE							
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR?			
		m.					
22. I hereby certify that I attended the deceased from July 20, 1955 to Nov. 28, 1955, that I last saw the deceased alive on 11/29, 1955, and that death occurred at 10:35 P.M. from the causes and on the date stated above.							
SIGNATURE Mabel C. Gray				DATE SIGNED			
(Degree or title)				ADDRESS			
Eudowood Sanatorium - Towson 4, Maryland							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Dec. 15, 55		Trinity Chapel		Rock Hall, Md.	
DATE RECD. BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Nov. 29, 1955		Mabel C. Gray		Edgar L. Lang		Church Hill, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NO.

100-100000

10598 CERTIFICATE OF DEATH

Reg. Dist. No. 38

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>505 VIRGINIA AVENUE</u>		LENGTH OF STAY (in this place)		STREET ADDRESS (if rural give location) <u>505 VIRGINIA AVENUE</u>			
3. NAME OF DECEASED: (First) <u>FRED</u> (Middle) <u>DENEY</u> (Last) <u>SUPE</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>NOV. 18, 1955</u>			
5. SEX: <u>MALE</u>		6. COLOR OR RACE: <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH: <u>JUNE 22, 1901</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>CABINET MAKER</u>		9. AGE last birthday <u>54</u> yrs. <u>54</u> Months <u>—</u> Days <u>—</u> Hrs. <u>—</u> Min. <u>—</u>		11. BIRTHPLACE (State or foreign country): <u>VIRGINIA</u>	
13. FATHER'S NAME: <u>STEPHEN SUPE</u>				14. MOTHER'S MAIDEN NAME: <u>NANNIE MILLER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) <u>NO</u> (If Yes, give war or dates of service) <u>NONE</u>				16. SOCIAL SECURITY NO. <u>227-05-4488</u>			
17. INFORMANT & ADDRESS: <u>FAMILY RECORDS</u>				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE <u>162X</u>				<u>8 MONTHS</u>			
ANTECEDENT CAUSE (B) <u>BRONCHIOGENIC CARCINOMA</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>OCT. 1955</u>				19B. MAJOR FINDINGS OF OPERATION: <u>BRONCHIOGENIC CARCINOMA WITH METASTASES</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				21B. PLACE (Home, farm, factory, etc.) OF INJURY <u>street, office bldg., etc.</u>			
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)							
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work			
21F. HOW DID INJURY OCCUR?							
2 I hereby certify that I attended the deceased from <u>July 6, 1955</u> , to <u>Nov. 18, 1955</u> , that I last saw the deceased alive on <u>Nov. 17, 1955</u> , and that death occurred at <u>3:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William A. Pillsbury</u>				ADDRESS <u>Towson</u>		DATE SIGNED <u>NOV. 18, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>				DATE THEREOF <u>NOV. 21, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>ROSELAWN CEMETERY</u>	
DATE REC'D BY LOCAL REGISTRAR <u>NOV. 19, 1955</u>				REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>		24. FUNERAL DIRECTOR <u>John Burnie' Sons, Towson, Md.</u>	
				LOCATION (City, town, or county) <u>MARION, VIRGINIA</u>		(State)	

STANDARD A-1

NOV

1956-08-01

10599

10603

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. **33**

Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Md. 		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Glyndon				CITY (If outside corporate limits write RURAL and give nearest town) TOWN Towson			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Tufts Ave.				STREET ADDRESS (If rural, give location) 214 bosley Ave.			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) Walter Hanson Shure Jr.				4. DATE OF DEATH (Month) (Day) (Year) Nov. 11, 1955 19			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH: July 17, 1930	9. AGE last birthday: 25 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Engineer aid State Roads			10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Walter H. Shure				14. MOTHER'S MAIDEN NAME: Doris Andersen			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: 212-30-5702		17. INFORMANT & ADDRESS: Walter H. Shure, 214 Bosley Ave. Towson			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							5 min.
Immediate cause (a)..... Crushed Skull, jaw & face DUE TO auto accident							
Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c).....							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. None.							
19a. DATE OF OPERATION: None.		19b. MAJOR FINDING OF OPERATION: None.					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Highway		21c. (City or town) (County) (State) Glyndon, Balto Md.			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY Nov 11 55 9:10 M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Car ran off rd & crushed.			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE D. D. Caples		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11-12-55 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM.					
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF Nov. 15/55		NAME OF CEMETERY OR CREMATORY Mt. Marie		LOCATION (City, town, or county) (State) Towson, Md.	
DATE REC'D BY LOCAL REG. 11-12-55		REGISTRAR'S SIGNATURE Mary D. Elmer		24. FUNERAL DIRECTOR John Burns Sons, Towson, Md.		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

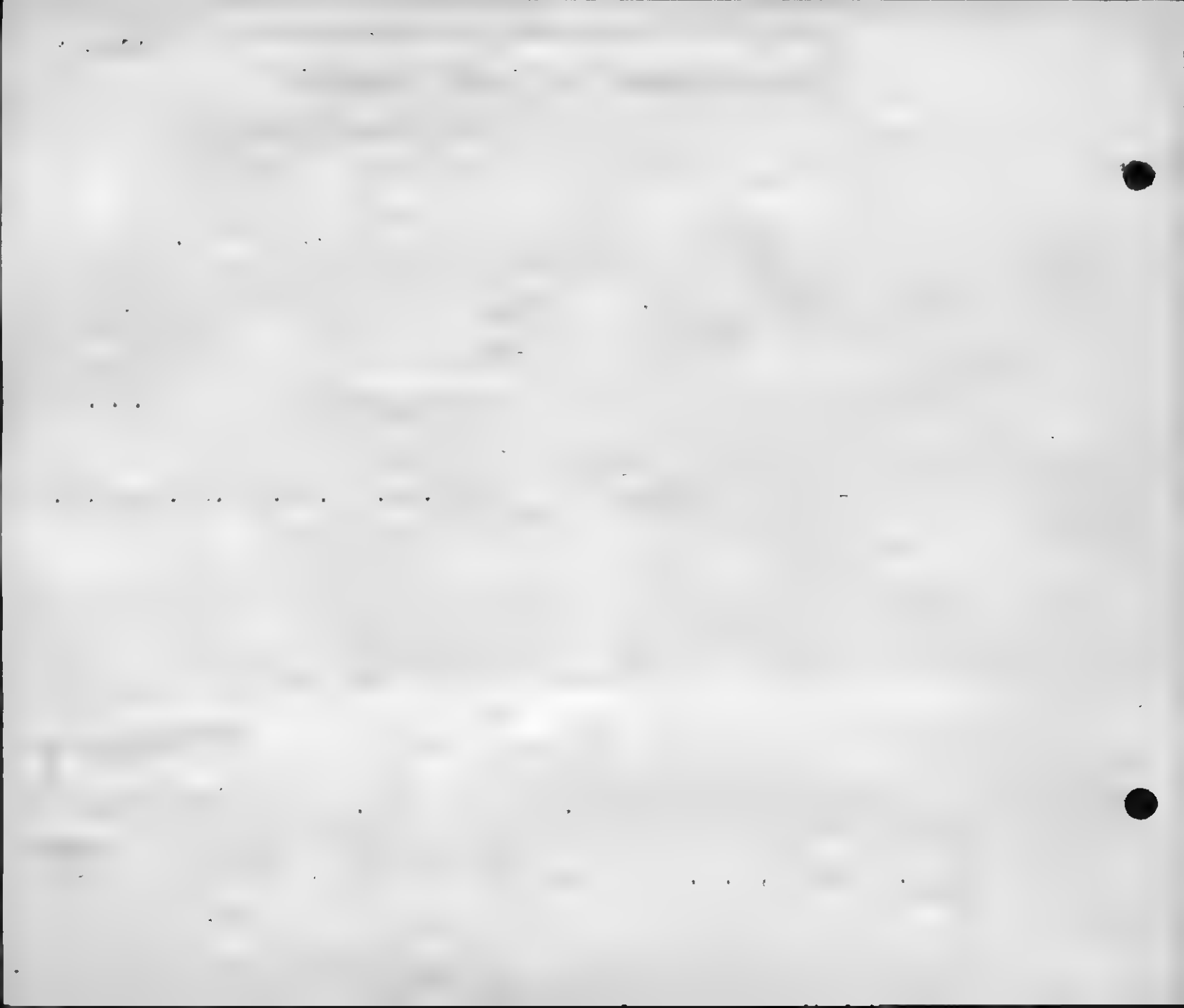
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10600 CERTIFICATE OF DEATH

10604

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY BALTIMORE		STATE MARYLAND		COUNTY Anne Arundel			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN FORT HOWARD		23 days		TOWN SEVERNA PARK		02X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL				STREET ADDRESS Route 2, Box 515 A. BENFIELD ROAD			
3. NAME OF DECEASED (Type or Print) EDWIN A. SNEERINGER				4. DATE OF DEATH November 1, 1955			
5. SEX MALE		6. COLOR OR RACE WHITE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED		8. DATE OF BIRTH 4-8-89	
9. AGE last birthday 66 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager				10b. KIND OF BUSINESS OR INDUSTRY Super Market		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Eugene Sneeringer				14. MOTHER'S MAIDEN NAME Sarah Kleindnst			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) YES WW-1				16. SOCIAL SECURITY NO. 216-03-7811		17. INFORMANT & ADDRESS Clin. Rec. Vet. Adm. Hesp. Ft. Howard Md.	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) HYPERTENSIVE CARDIOVASCULAR DISEASE				UNKNOWN			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct. 9, 1955, to Nov. 1, 1955, and that death occurred at 6:40 P.M. from the causes and on the date stated above.							
SIGNATURE William B. Vandegrift, M.D.				ADDRESS (Street, city, town, state) VAH, FORT HOWARD, MARYLAND			
DATE 11-2-55				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 11/5/55		NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE L. J. DeAlba		25. FUNERAL DIRECTOR'S SIGNATURE Hopping & Kirby Funeral Home		ADDRESS 421 Crain Hwy. Glen Burnie, Md.	



10601 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY OR TOWN <u>Riderwood</u>		LENGTH OF STAY (in this place) <u>2 days</u>		CITY OR TOWN <u>Bel Air</u>		<u>12-22-</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sorenson Nursing Home</u> <u>7912 Ruxway</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Russell C. Stanley</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 20 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 28, 1888</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Odd Jobs</u>		11. BIRTHPLACE (State or foreign country) <u>Williamsport Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Henry Stanley</u>				14. MOTHER'S MAIDEN NAME <u>Ruthie Jane Cramer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>?</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. James Marion East Cranstn.</u> <u>410 PROSPECT ST</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
154X IMMEDIATE CAUSE (A) <u>Myocardial failure acute</u>				INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocarditis chronic</u>				<u>3 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Malignancy with metastasis</u>				<u>recent</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Rectal malignancy with metastasis</u>				<u>recent</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		<u>See record at Johns Hopkins Hospital</u>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
				<u>no injury</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>no injury</u>				<u>no injury</u>			
22. I hereby certify that I attended the deceased from <u>Nov. 11, 1955</u> , to <u>Nov. 20, 1955</u> , that I last saw the deceased alive on <u>Nov. 11, 1955</u> , and that death occurred at <u>1:30 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>James Graham Manton</u>				ADDRESS (Street, city, town, state) <u>516 Cathedral St. Balto. Md</u>			
DATE <u>Nov. 22, 55</u>				DATE SIGNED <u>Nov. 22, 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov 22 55</u>		NAME OF CEMETERY OR CREMATORY <u>Walters Mem. Park</u>		LOCATION (City, town, or county) (State) <u>Bel Air Md</u>	
24. REC'D BY REGISTRAR <u>Mabel Grays</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Keith</u>		ADDRESS <u>700 N. ...</u>	
DATE <u>Nov. 30, 1955</u>							

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

Salisbury

Thurs/Nov

1885

Oct 21

Russell G. Stanley

Nov. 20 22

John White, W. Lewis, Nov 22, 1885

"

Robert O. Jones, William H. Jones, Nov 22

George Henry Stanley

1

John G. Jones, George H. Jones

Nov 22, 1885

1885

Nov 22, 1885

Nov 22

10602 CERTIFICATE OF DEATH

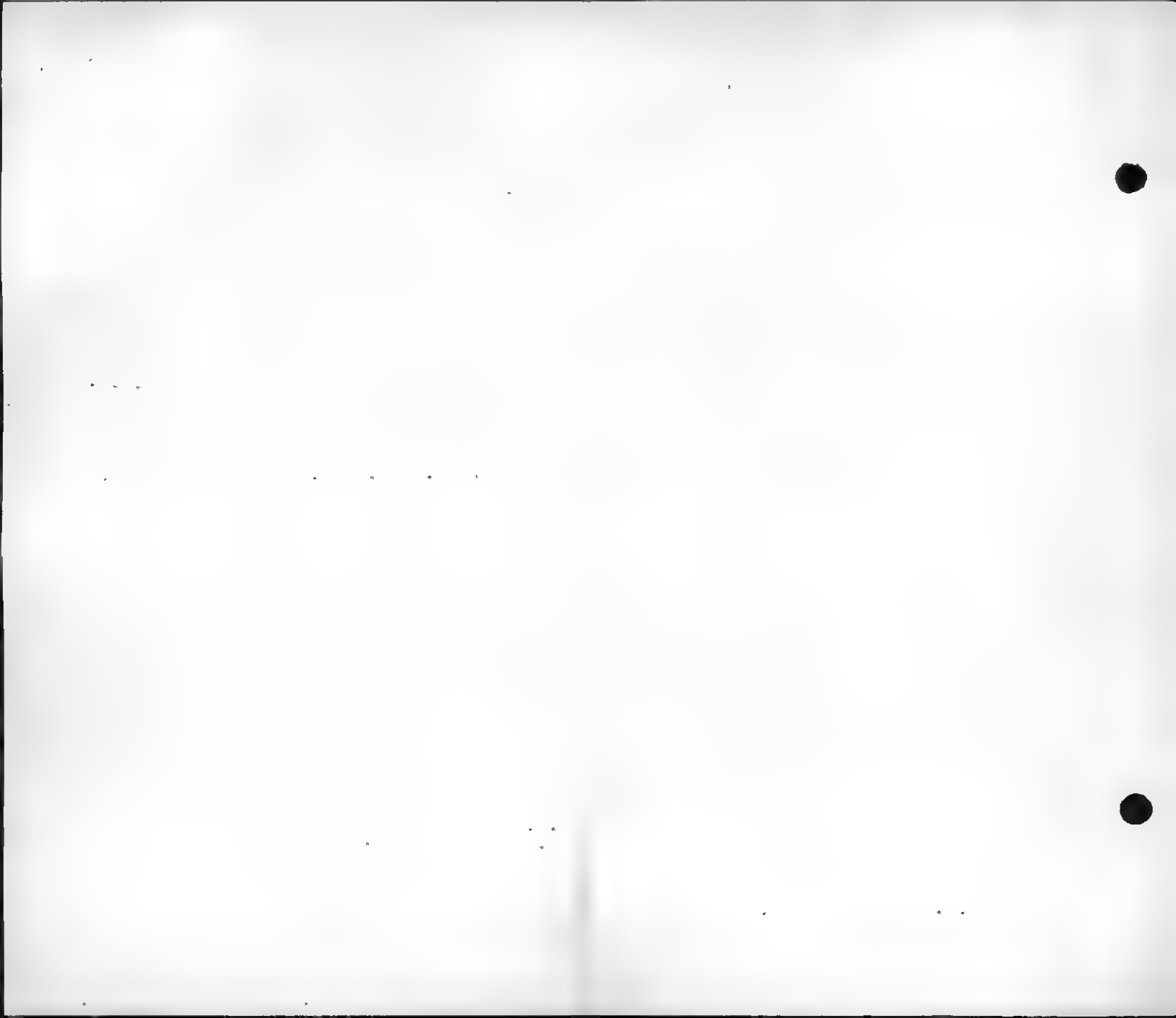
Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:				
COUNTY <u>BALTIMORE</u> MARYLAND				STATE <u>MARYLAND</u> COUNTY				
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>FORT HOWARD</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u>				
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>6765 GRACELAND AVENUE</u>				
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE (Month) (Day) (Year)					
JOHN (NMI) STINACH			DATE OF DEATH: <u>11-24-55</u> 19					
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
Male	WHITE	SINGLE	11-27-21	33 yrs.	Months	Days	Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARTENDER</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>TAVERN</u>		11. BIRTHPLACE (State or foreign country): <u>PHILADELPHIA, PENNSYLVANIA</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>ANDREW STINACH</u>				14. MOTHER'S MAIDEN NAME: <u>SOPHIE KOBALY</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WW II</u>			16. SOCIAL SECURITY No. <u>164-18-4883</u>		17. INFORMANT & ADDRESS: <u>Vet. Adm. HOSP. CLIN. REC., FT. HOWARD, MD.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH								
IMMEDIATE CAUSE (A) <u>PNEUMONITIS, RIGHT AND LEFT LOWER LOBES</u>							1 WEEK	
ANTECEDENT CAUSE (B) DUE TO								
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>581.0</u>								
(C) DUE TO								
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CIRRHOSIS OF LIVER</u>								
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
			M. 9:15 P.M.		1:55 AM			
22. I hereby certify that I attended the deceased from Nov. 23, 19 55 to Nov. 24, 19 55 that I last saw the deceased on Nov. 24, 19 55 and that death occurred at 1:55 M, from the causes and on the date stated above.								
SIGNATURE <u>C.J. Papastat, M.D.</u>				ADDRESS <u>FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>11-24-55</u>		
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>11-28-55</u>		NAME OF CEMETERY OR CREMATORY <u>SACRED HEART OF MARY CEMETERY BALTIMORE 22, Maryland</u>		LOCATION (City, town, or county) (State)		
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS <u>WALTER DANKOWSKI FUNERAL HOME 1001 Dundalk Ave., Baltimore 24, Md.</u>				

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians:— please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10607

10603

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Wilton</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Wilton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>603 WILTON RD</u>				STREET ADDRESS (If rural, give location) <u>603 WILTON RD</u>			
3. NAME OF DECEASED (First) <u>William</u> (Middle) <u>Reynold</u> (Last) <u>TAPSCOTT</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>23</u> Year <u>1955</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>Sept 4 1894</u>		9. AGE last birthday <u>61</u> yrs.		10. If under 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SENIOR PLANNER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARTIN A C</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Reubin Deville TAPSCOTT</u>			
14. MOTHER'S MAIDEN NAME <u>Alice Laporte</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>WNI</u>			
16. SOCIAL SECURITY NO. <u>005-01-0980</u>				17. INFORMANT <u>JEANETTE TAPSCOTT 603 WILTON RD</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> Immediate cause (a) <u>Decompensation Cardio Vascular Disease</u> Antecedent cause(s) (b) <u>Coronary Thrombosis</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)						INTERVAL BETWEEN ONSET AND DEATH	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 10, 1949</u> to <u>Nov 23, 1955</u> , that I last saw the deceased alive on <u>Nov 23, 1955</u> , and that death occurred at <u>5:30 P. m.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Lawrence C. Fosh</u>		(Degree or title) <u>M.D.</u>		ADDRESS <u>6805 York Rd Baltimore 12 Md</u>		DATE SIGNED <u>11/25/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>Nov 26, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>PROVID RIDGE</u>		LOCATION (City, town, or county) (State) <u>BALTO Md</u>	
DATE REC'D BY LOCAL REG. <u>11/26/55</u>		REGISTRAR'S SIGNATURE <u>G. W. Bacon</u>		24. FUNERAL DIRECTOR <u>Chas F Evans & Son</u>		ADDRESS <u>8802 HARFORD RD</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6805 York Rd

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN ☐ **HOSPITAL:** The ☐ requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10604

CERTIFICATE OF DEATH

10608

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>LODGE FOREST (19)</u>		<u>5 MO.</u>		OR TOWN <u>DUNDALK (22)</u>		<u>53</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
90 <u>CARROLL NURSING HOME</u>				<u>15 TOWNSHIP RD.</u>		<u>1</u>	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JAMES</u> (Middle) <u>BOWEN</u> (Last) <u>THOMAS</u>				(Month) <u>11</u> (Day) <u>24</u> (Year) <u>1955</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>JULY 17, 1877</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL MILL</u>		11. BIRTHPLACE (State or foreign country) <u>WALES</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>NO</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-07-1348A</u>		17. INFORMANT & ADDRESS <u>JAMES THOMAS - SAME</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <u>Central Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio sclerosis generalized</u>						<u>5 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-17</u> 19 <u>55</u> , to <u>11-24-55</u> 19 <u>55</u> , that I last saw the deceased alive on <u>11-24-55</u> 19 <u>55</u> , and that death occurred at <u>3:51 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Jack Challinor</u>				DATE SIGNED <u>11-26-55</u>			
ADDRESS (Street, city, town, state) <u>M.D. 2 Township Rd. Balt 22</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-28-55</u>		NAME OF CEMETERY OR CREMATORY <u>Morden & Mem. Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore County, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Larson L. Harbor</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Broke Bradley</u>		ADDRESS <u>Dundalk, Md</u>	
DATE <u>11-28-55</u>							

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10605 CERTIFICATE OF DEATH

Reg. Dist. No.

10609

32

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN <u>Rural Garrison</u>	LENGTH OF STAY (in this place) <u>26 yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Garrison</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <u>Reisterstown Rd., Garrison, Md.</u>	

3. NAME OF DECEASED: (Type or Print) <u>Harry</u> <u>Charles</u> <u>Thomson</u>		4. DATE OF DEATH: (Month) <u>Nov.</u> (Day) <u>18</u> (Year) <u>19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>June 26, 1885</u>
9. AGE last birthday: <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>owner</u>	11. BIRTHPLACE (State or foreign country): <u>Chicago, Ill.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>George R. Thomson</u>	
14. MOTHER'S MAIDEN NAME: <u>Mary Root</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>yes</u> <u>W.W.I</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mrs. Hattie Thomson, Garrison, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>arteriosclerotic heart disease</u>		<u>2 yrs.</u>
ANTECEDENT CAUSE (B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from <u>June, 1948</u> , to <u>Nov</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>22 Oct</u> , 19 <u>55</u> , and that death occurred at <u>6 A.M.</u> , from the causes and on the date stated above.				
SIGNATURE <u>Paul H. Royse</u>		ADDRESS <u>Pikesville 8 rd</u>		DATE SIGNED <u>18 Nov 55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>Nov. 21, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Loudon Park Crematory</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
DATE REC'D BY LOCAL REGISTRAR <u>Nov. 19, 1955</u>	REGISTRAR'S SIGNATURE <u> Dorothy A. Newell</u>	24. FUNERAL DIRECTOR'S ADDRESS <u>Frank H. Newell, Pikesville</u>		

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOV 22 1955

NOV 22 1955

NOV 22 1955

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10610

10606 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>		STATE <u>Maryland</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural give location) <u>2519 Christian Street</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Louis C. Tiedemann</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>November 9, 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>5-7-1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired R.R. man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B+O</u>	9. AGE last birthday <u>69</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Tiedemann</u>		14. MOTHER'S MAIDEN NAME <u>Caroline?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS <u>Records Spring Grove State Hospital</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) <u>Cerebrovascular accident</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work Not while at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10-25-1955, to 11-9-1955, that I last saw the deceased alive on 11-9-1955, and that death occurred at 8:00 AM, from the causes and on the date stated above.			
SIGNATURE <u>Harold E. Edwards, M.D.</u>		DATE SIGNED <u>11-9-55</u>	
ADDRESS (Street, city, town, state) <u>Spring Grove State Hospital</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>11/12/55</u>	NAME OF CEMETERY OR CREMATORY <u>LONDON PARK</u>	LOCATION (City, town, county) (State) <u>Catonsville, 28, Md.</u>
24. REC'D BY REGISTRAR <u>Nov 10, 1955</u>	REGISTRAR'S SIGNATURE <u>Victor E. Henry</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witte</u>	ADDRESS <u>4101 EDMONDSON</u>



10607 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)X TOWN Owings MillsLENGTH OF STAY
(in this place)

5 yrs.

HOSPITAL OR
INSTITUTION OR

STREET ADDRESS

12 Rosewood State Tr. School

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)
ORTOWN Baltimore 20, MarylandSTREET
ADDRESS

(If rural give location)

37 Compass Road

3. NAME OF
DECEASED:
(Type or Print)

(First)

Kenneth

(Middle)

George

(Last)

Tobias

4. DATE (Month)

(Day)

(Year)

OF
DEATH. 112019 55

5. SEX.

male6. COLOR OR
RACEwhite7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify):single

8. DATE OF BIRTH:

9/5/47

9. AGE last birthday

8

yrs.

Months

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life,
even if retired):10B. KIND OF BUSINESS
OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

Oregon12. CITIZEN OF WHAT
COUNTRY?U.S.A.

13. FATHER'S NAME:

Harry Clair Tobias

14. MOTHER'S MAIDEN NAME:

Lillian Marie Vaughan15. WAS DECEASED EVER IN U.S. ARMED FORCES
(Yes, no, or unk.) (If Yes, give war or dates
of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS:

Rosewood Records

18. MEDICAL CERTIFICATION

DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

355X

IMMEDIATE CAUSE

(A)

Inspiratory pneumonia

DUE TO

ANTECEDENT CAUSE (B)

(B)

Schilder's Disease (Encephalitis periaxialis 19 mo. of

DUE TO

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

(C)

diffusa with symptomatic epilepsy)INTERVAL BETWEEN
ONSET AND DEATH1 day11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
While ☐ Not while ☐
M. at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/19/, 19 55, to 11/20/, 19 55, that I last saw the deceasedalive on 11/20/, 19 55, and that death occurred at 8:55 AM, from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

Harry G. ButlerM.D. Owings Mills Md.11/21/5523. BURIAL CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATOR

LOCATION (City, town, or county)

(State)

burial11/22/55Baltimore NationalBaltimore,MarylandDATE REC'D BY LOCAL
REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

11-22-55A. W. HedrickWm. Cook, Inc.1217 St. Paul St.

MARGIN RESERVED FOR BINDING -



10608 CERTIFICATE OF DEATH

Reg. Dist. No. 16

1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) Lodge Forest LENGTH OF STAY (in this place) 2 WEEKS
 OR TOWN Lodge Forest
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 7704 BAYFRONT RD.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY TALBOT
 CITY (If outside corporate limits, write RURAL and give nearest town) EASTON
 OR TOWN 2040-3
 STREET ADDRESS (If rural, give location) 205 NYE AVE.

3. NAME OF DECEASED:

(First) (Middle) (Last)
ALGA MCGUAY TOWERS

4. DATE OF DEATH: (Month) (Day) (Year)
NOV. 9 19 55

5. SEX:

MALE

6. COLOR OR RACE:
WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED

8. DATE OF BIRTH:

AUG. 6, 1877 78 yrs.

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER

10b. KIND OF BUSINESS OR INDUSTRY: SELF-EMPLOYED

11. BIRTHPLACE (State or foreign country): TALBOT CO. MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

Andrew J. Towers

14. MOTHER'S MAIDEN NAME:

Elizabeth A. Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
NO

16. SOCIAL SECURITY No.: NONE

17. INFORMANT & ADDRESS:

DAUGHTER, EUNICE CEDAREGG - 7704 BAYFRONT RD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

151X Immediate cause (a) Carcinomatosis
 DUE TO

Antecedent cause(s) (b) Carcinoma of stomach
 Diseases or conditions, if any, giving rise to the above cause stating underlying cause last DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

2 mos.

1 yr. ±

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

? C Carcinoma of stomach.

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 5, 1955 to Nov. 9, 1955, that I last saw the deceased alive on Nov. 9, 1955, and that death occurred at 9:15 P.M., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

November 12, 1955. R.W.

Muriel C. Newman & Son

Easton, MD

MARGIN RESERVED FOR BINDING

[illegible]

42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1041 1042 1043 1044 1045 1046 1047 1048 1049 1050 1051 1052 1053 1054 1055 1056 1057 1058 1059 1060 1061 1062 1063

~~LL~~ 82 552

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be delivered for use as a burial transit permit.

VS A15C 155 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10609

CERTIFICATE OF DEATH

10613

Reg. Dist. No. 29

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore County</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Riderwood</u>		<u>14 days</u>		TOWN <u>Cockeysville Maryland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Sorensen Nursing Home</u>				<u>7912 Kuxway Riderwood Md</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Clara A. Tracey</u>				<u>November 14, 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>female</u>	<u>white</u>	<u>single</u>	<u>7-1-1975</u>	<u>80</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>housekeeper home</u>		<u>home</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Melchoir A. Tracey</u>				<u>Elizabeth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or ink)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>no</u>		<u>Mrs Julia Tracey, 7912 Kuxway, Riderwood, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>151X</u>				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A)				<u>anemia from hemorrhage</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Carcinoma of stomach</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<u>General metastasis, malignant</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Advancing years.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>none</u>		<u>no operation</u>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<u>none</u>		<u>none</u>		<u>none</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
<u>none</u>		<u>White at work</u> <input type="checkbox"/> <u>Not white at work</u> <input type="checkbox"/>		<u>none</u>			
22. I hereby certify that I attended the deceased from <u>Nov. 6, 1955</u>, to <u>Nov. 14, 1955</u>, that I last saw the deceased alive on <u>Nov. 6, 1955</u>, and that death occurred at <u>10 M.</u> from the causes and on the date stated above							
SIGNATURE				ADDRESS (Street, city, town, state)			
<u>James G. Mantor</u>				<u>516 Cathedral Street II-15-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>11-17-55</u>		<u>Black Rock</u>		<u>Butler, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Nov. 17, 1955</u>		<u>Mabel C. Gray</u>		<u>L. Scott Brock, Sparks, Md.</u>			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10614

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 33

10614
Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>md</i>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Baltimore</i>		LENGTH OF STAY (in this place) <i>2</i>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <i>Baltimore</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>100 ...</i>				STREET ADDRESS (If rural, give location) <i>2812 ...</i>			
3. NAME OF DECEASED: (Type or Print) <i>EDWIN THOS TREISCHMAN</i>				4. DATE OF DEATH <i>Nov. 25</i> 19 <i>55</i>			
5. SEX: <i>Male</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH: <i>Feb 20 1905</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Partender at Tavern</i>		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday: <i>50</i> yrs.		11. BIRTHPLACE (State or foreign country): <i>md</i>	
13. FATHER'S NAME: <i>Charles A Treischman</i>				14. MOTHER'S MAIDEN NAME: <i>Sadie Shirley</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):				16. SOCIAL SECURITY No.: <i>216-09-0156</i>		17. INFORMANT & ADDRESS: <i>3819 Hayward Ave Balto 15 md</i>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<p><i>4</i> Immediate cause (a) ... <i>Coronary Occlusion</i> DUE TO</p> <p>Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause DUE TO</p> <p>stating underlying cause last (c)</p>						<p><i>1 hr.</i></p>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>None.</i>							
19a. DATE OF OPERATION: <i>None</i>				19b. MAJOR FINDING OF OPERATION: <i>None</i>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>None</i>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <i>None</i>		21c. (City or town) (County) (State) <i>None</i>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>None</i> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>None</i>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <i>D. D. Caplan</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/> <i>11-25-55</i>			
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>		DATE THEREOF <i>Nov 28/55</i>		NAME OF CEMETERY OR CREMATORY <i>mt Olive</i>		LOCATION (City, town, or county) (State) <i>Randallstown md</i>	
DATE REC'D BY LOCAL REG. <i>11-26-55</i>		REGISTRAR'S SIGNATURE <i>Mary B. Elmer</i>		24. FUNERAL DIRECTOR <i>Loring Egan</i> ADDRESS <i>5005 Philadelphia Balto 15, Md.</i>			

10611 CERTIFICATE OF DEATH

Reg. Dist. No. 3

I. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

X TOWN Rural: Towson

HOSPITAL OR INSTITUTION OR

01 STREET ADDRESS Eudowood Sanatorium
Towson 4, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

OR

TOWN Balto. 13

3 Vol 1 4

STREET ADDRESS

(If rural give location)

3515 Juneway

3. NAME OF DECEASED:

(Type or Print)

(First)

(Middle)

(Last)

RAYMONDE.TYLER

4. DATE OF DEATH:

(Month)

(Day)

(Year)

Nov311955

5. SEX:

M

6. COLOR OR RACE:

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Married

8. DATE OF BIRTH:

Dec 20 1900

9. AGE last birthday: (If UNDER 1 YEAR)

54

yrs.

Months Days

Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired

admission writer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

Balto. Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Theodore Tyler

14. MOTHER'S MAIDEN NAME:

Grace Lewis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

213-03-5721

17. INFORMANT & ADDRESS:

Personal HistoryHospital Records, Eudowood Sanatorium

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

002 X

Immediate cause

(a)

DUE TO

Pulmonary Tuberculosis

Antecedent causes(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between Onset And Death

10 yr

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 16, 1955, to Nov 30, 1955, that I last saw the deceased alive on Nov 29, 1955, and that death occurred at 1:25 P.M. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

11/30/55WWendell Leonard Ruck5305 NaylorBaltoSC 2

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct are is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10458

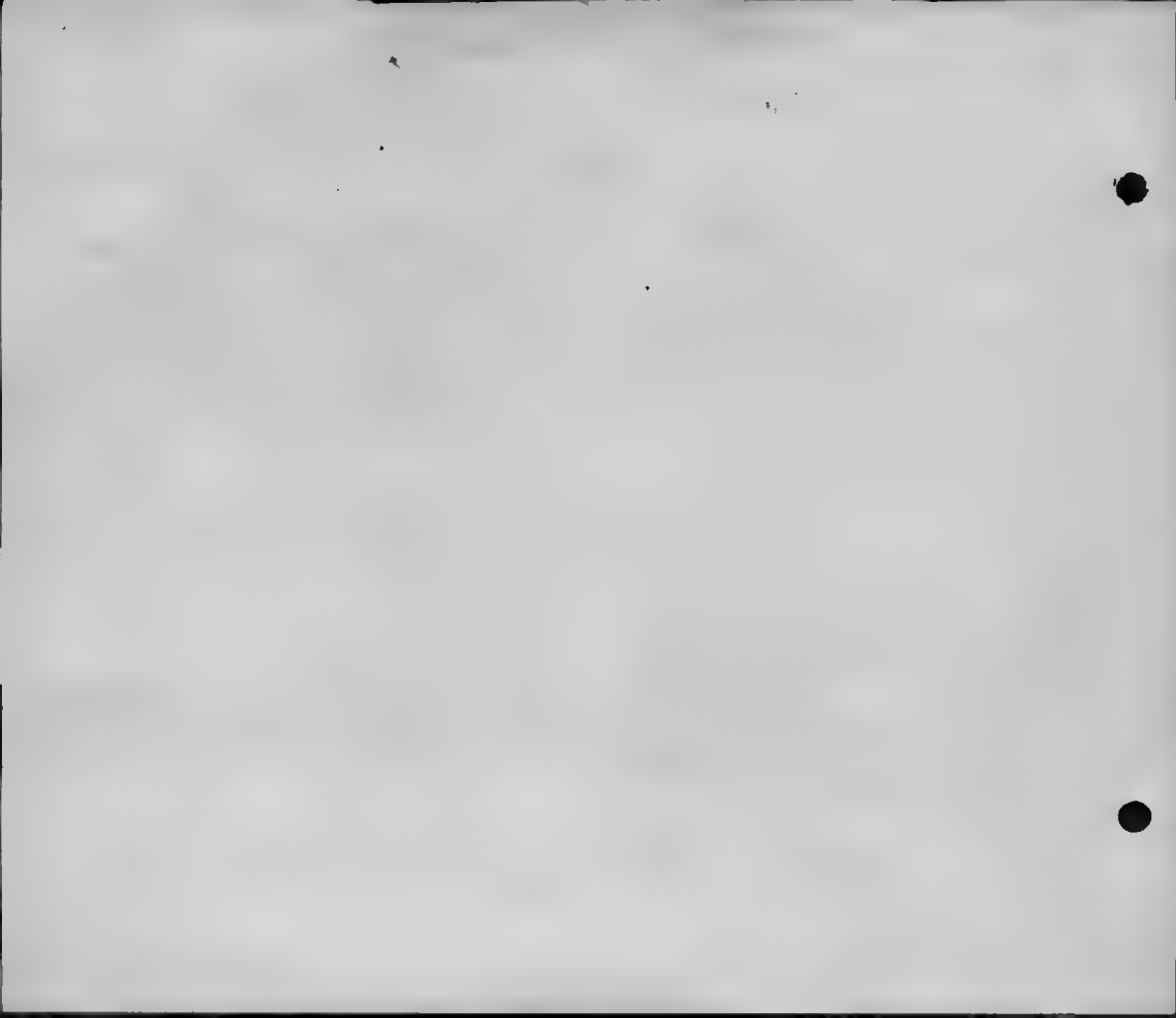
10616
Reg. Dist.

No. 41

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Md.		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Rosedale		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Rosedale			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Air Port Beach				STREET ADDRESS (If rural, give location) 4311 Glenmore Avenue			
3. NAME OF DECEASED: (Type or Print) Arthur		(First) M.		(Last) Valentine		4. DATE OF DEATH 11 17 1955	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced	8. DATE OF BIRTH: Nov. 13, 1903		9. AGE last birthday: 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Clerk		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Henry A. Valentine				14. MOTHER'S MAIDEN NAME: Irene Kratz			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No.		16. SOCIAL SECURITY No.: 214-05-6404		17. INFORMANT & ADDRESS: Henry A. Valentine 4511 Glenmore Ave.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
927.8 Immediate cause (a) Drowning DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) INJURY water		21c. (City or town) Air Port Beach		(County) Baltimore	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY Found 11/17/55		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Found drowned			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .							
SIGNATURE Paul F. Men		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
				DATE SIGNED 11/18/55			
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF Nov. 19, 1955		NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		LOCATION (City, town, or county) (State) Colgate, Md.	
DATE REC'D BY LOCAL REG. 11-18-55		REGISTRAR'S SIGNATURE A. H. Harkness		24. FUNERAL DIRECTOR Ullrich Funeral Home 4210 Belair Road.		ADDRESS	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 48 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

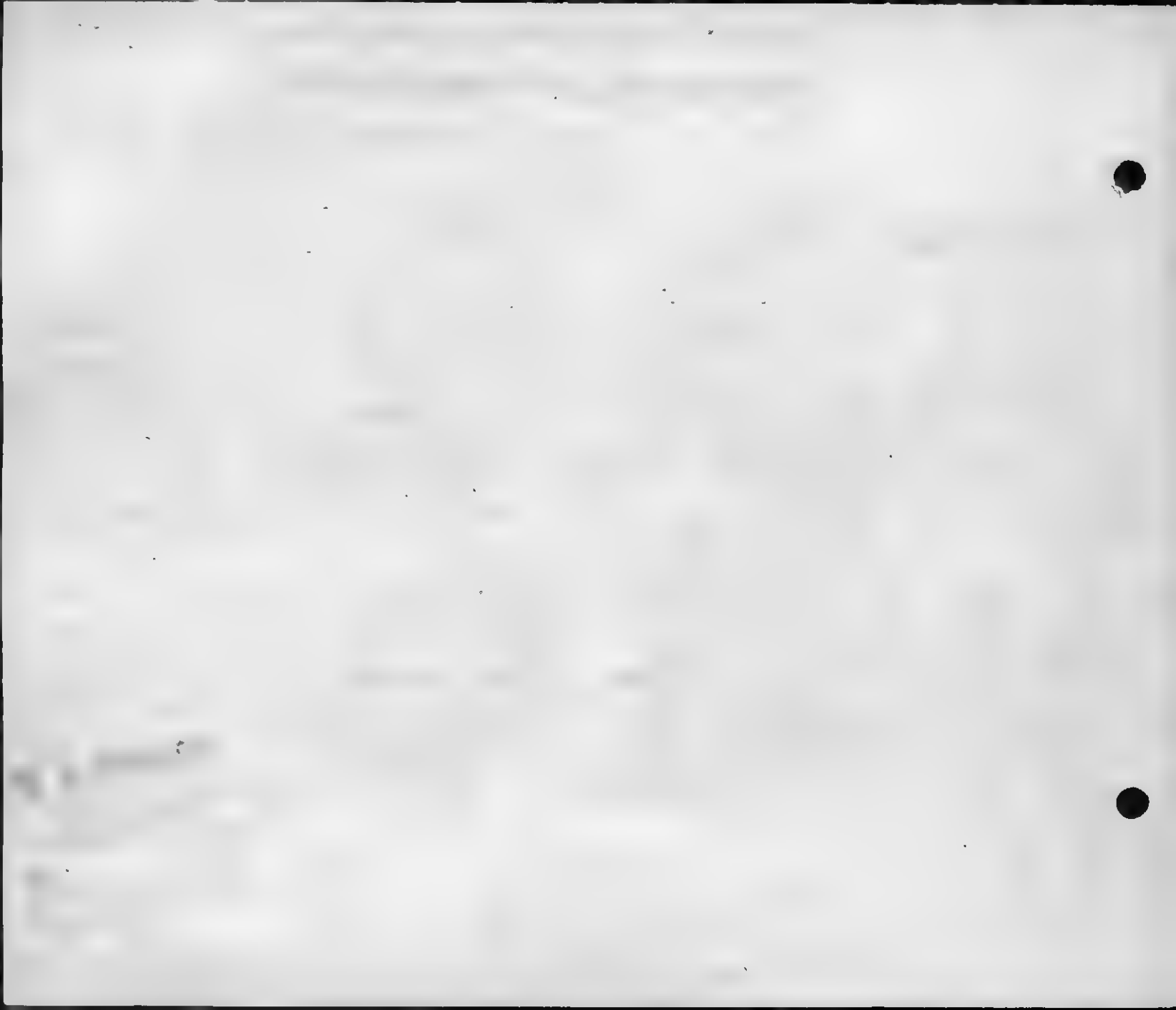
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10617

10612 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO. CO.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO.</u>	
CITY OR TOWN <u>CATONSVILLE</u>		LENGTH OF STAY (In this place) <u>LIFE</u>		CITY OR TOWN <u>CATONSVILLE</u>		57	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>105 MONTROSE AVE</u>				STREET ADDRESS <u>105 MONTROSE AVE.</u>		1	
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>RAYMOND F. WALDVOGEL</u>				<u>11/20/55</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>AUG. 21, 1892</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interior Decorator</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>PA.</u>	
13. FATHER'S NAME <u>HENRY C. WALDVOGEL</u>				14. MOTHER'S MAIDEN NAME <u>MARI-ARTHUR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Agnes Waldvogel</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
163X IMMEDIATE CAUSE (A) <u>Broncho-Pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u>	
ANTECEDENT CAUSE(S) (B) <u>Adeno-carcinoma of Lung</u>						<u>2 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (C) <u>General Metastasis</u>						<u>1 year</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>1954</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma - adenocarcinoma - right lung -</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7:45</u> to <u>11:20</u> on <u>11-18</u> 1955 and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. E. Harry</u>				ADDRESS (Street, city, town, state) <u>6000 South 28th St. Balto. 28</u>		DATE SIGNED <u>11/21/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>11/23/55</u>		NAME OF CEMETERY OR CREMATORY <u>LORRAINE</u>		LOCATION (City, town, or county) <u>BALTO. CO.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>T. E. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>MACNABB & SON</u>		ADDRESS	
DATE <u>11/21/55</u>							



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10613

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 10618
 Reg. Dist.

No. 45

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>ESSEX</u>				TOWN <u>ESSEX</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>300 LORRAINE AVE.</u>				STREET ADDRESS (If rural, give location) <u>300 LORRAINE AVE.</u>			
3. NAME OF DECEASED: (First) <u>JOHN</u>		(Middle) <u>WADE</u>		(Last) <u>WALTER</u>		4. DATE OF DEATH	
(Type or Print)						NOV. 18 19 55 IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>7 - 15 - 1883</u>	9. AGE Last birthday: <u>72</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>POLICEMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME: <u>JOHN W. WALTER</u>				14. MOTHER'S MAIDEN NAME: <u>CORNELIA FOX</u>			
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY No.: <u>213 - 07 - 5409</u>		17. INFORMANT & ADDRESS: <u>ANNIE WALTER 300 LORRAINE AVE.</u>			
(If Yes, give war or dates of)							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 4. Immediate cause (a) <u>Antecedent cause(s)</u> DUE TO <u>Heart Disease</u> Diseases or conditions, if any, (b) giving rise to the above cause DUE TO <u>Heart Disease</u> stating underlying cause last (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>John C. Collins</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11-18-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>11/21/55</u>		NAME OF CEMETERY OR CREMATORY <u>EMERY CEMETRY</u>		LOCATION (City, town, or county) (State) <u>CORROL CO. NTY</u>	
DATE REC'D BY LOCAL REG. <u>11/18/55</u>		REGISTRAR'S SIGNATURE <u>Earl Hurley</u>		24. FUNERAL DIRECTOR <u>BRUDZINSKI FUNERAL HOME</u>		1407 ADDRESS <u>EASTERN AVE.</u>	



10614 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write OR and give nearest town) <u>52 Catonsville</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write OR and give nearest town) <u>Baltimore, Md.</u>	<u>3401-4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural give location) <u>802 Ridgely St.</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(Type or Print) <u>Beulah</u>	(First) (Middle) (Last) <u>Warrell</u>	<u>11 6 1955</u>	
5. SEX: <u>F.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> (Specify)	8. DATE OF BIRTH: <u>FEB. 17, 1892</u>
9. AGE last birthday <u>63</u> yrs		IF UNDER 1 YEAR: Months Days Hours Mins.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME: <u>? Foos</u>		14. MOTHER'S MAIDEN NAME: <u>? MichA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT & ADDRESS: <u>Mr. Leroy Warrell - Herlock, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
443X IMMEDIATE CAUSE (A) <u>Hypertensive cardiovascular disease</u>			
ANTECEDENT CAUSE (S) (B) <u>Pneumonia</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>April 1, 1955</u> , to <u>Nov. 5, 1955</u> , that I last saw the deceased alive on <u>11-5-1</u> , 1955, and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>James Williams</u>		DATE SIGNED <u>Nov. 9, 1955</u>	
ADDRESS <u>M.D. Spring Grove State Hospital Catonsville</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 9, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Anne Arundel Co., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11/9/55</u>		REGISTRAR'S SIGNATURE <u>G. H. Houch</u>	
24. FUNERAL DIRECTOR <u>G. W. Tiekner & Sons, Inc.</u>		ADDRESS <u>Balto., Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



10615 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Fort Howard		22 Days		TOWN Baltimore - 35			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital				STREET ADDRESS (If rural give location) 218 Walnut Avenue			
3. NAME OF (First) (Middle) (Last)			4. DATE OF DEATH (Month) (Day) (Year)				
LAWTON WASHINGTON			November 15 19 55				
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	Colored	Married	9/15/91	64	Months	Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Handyman			Odd Jobs		Culpepper, Virginia		U. S. A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Arthur Washington				Ada Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
Yes WW I			577-26-9397		Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.		
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
163x IMMEDIATE CAUSE (A) CARCINOMA LEFT LUNG						UNKNOWN	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct. 24, 1955, to Nov. 15, 1955, and that death occurred at 2:07 P.M. from the causes and on the date stated above.		ADDRESS (Street, city, town, state) DATE SIGNED					
WILLIAM B. VANDEGRIFT, M. D.		M. D. VAH, FORT HOWARD, MARYLAND		11-16-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal		11/18/55		Mt. Zion Baptist Church		Atlantis, Virginia	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Nov. 19-55		Doris L. Farber		Charles R. Law		802-04 Madison Av. Baltimore 1, Md.	

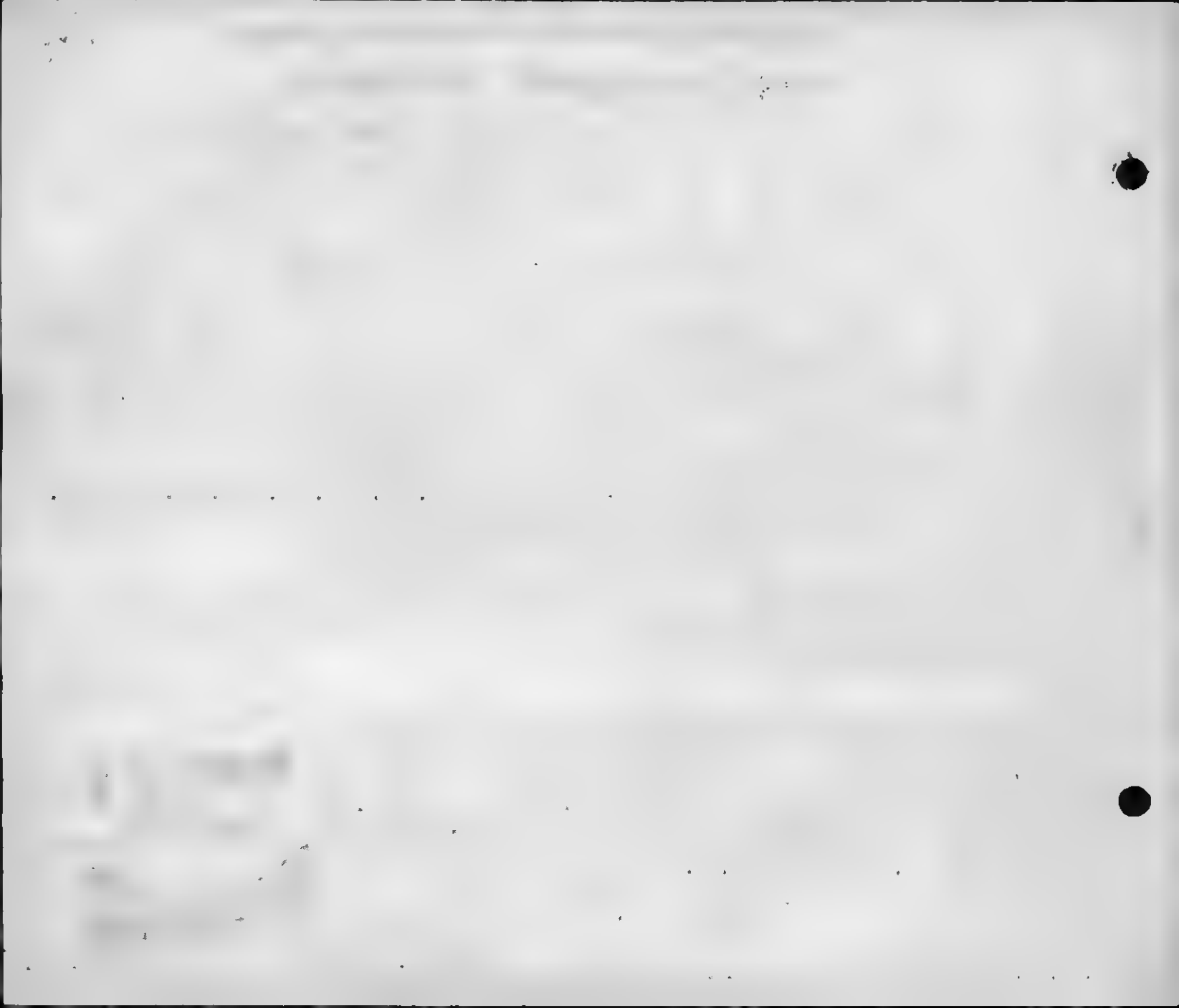
INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The bottom copy may be retained by the hospital or attending physician.

VS AISC 1-55 10M

Ship to Morris Marshall Funeral Home, Davis St. Culpeper, Virginia



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 101

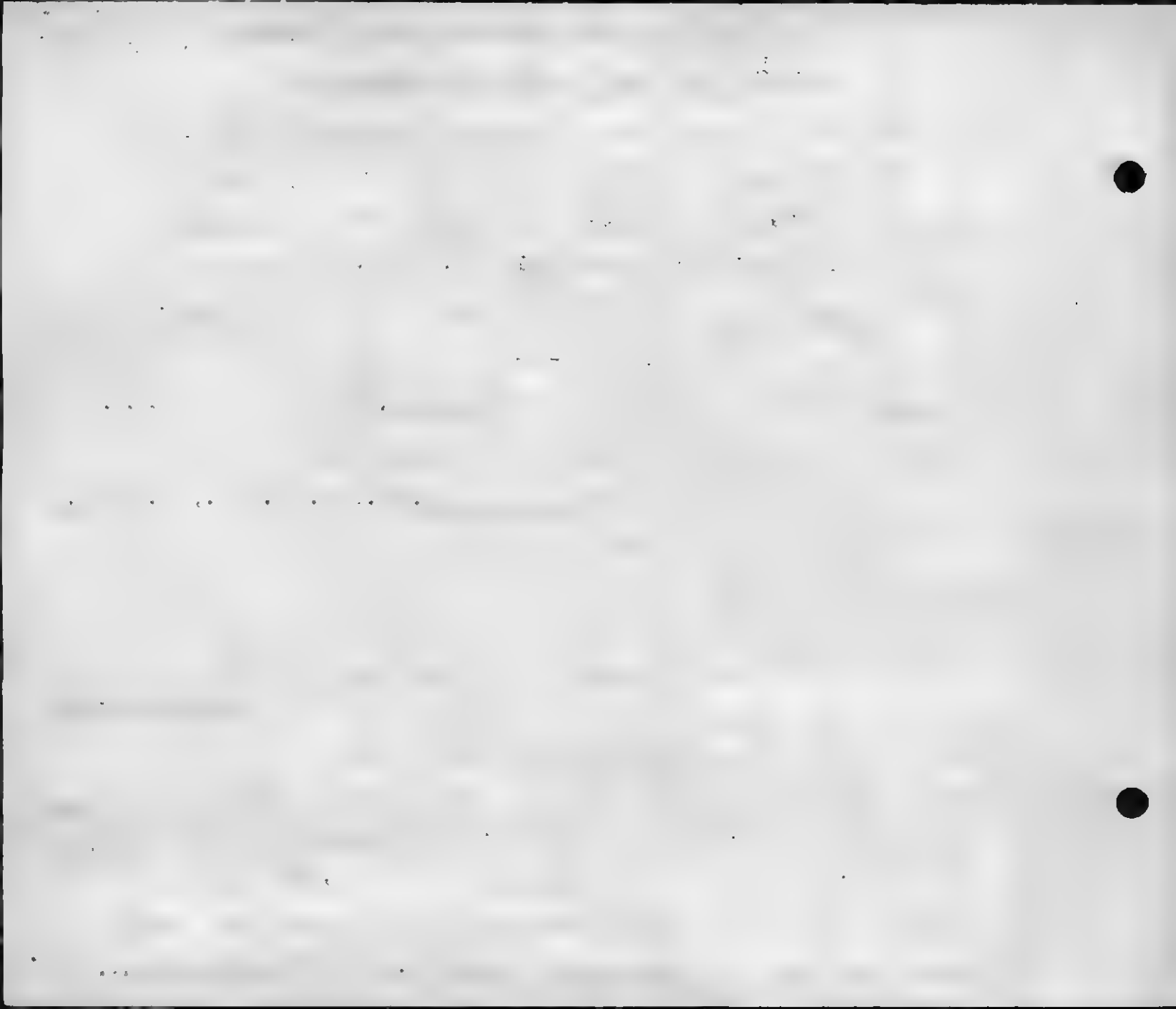
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10621

10616 CERTIFICATE OF DEATH

Reg. Dist. No. *44*

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME OF DECEASED)			
COUNTY Baltimore		STATE Maryland		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) Fort Howard,		LENGTH OF STAY (in this place) 4 days		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS (If rural give location) 1626 N. Fulton Avenue					
3. NAME OF DECEASED (Type or Print) PHILLIP E WATKINS				4. DATE OF DEATH (Month) (Day) (Year) November 5 19 55			
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 5-21-87	9. AGE last birthday 68 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.		11. BIRTHPLACE (State or foreign country) Calvert Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Watkins				14. MOTHER'S MAIDEN NAME Sarah Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT & ADDRESS Clip. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
151X IMMEDIATE CAUSE (A) CARCINOMA OF STOMACH						2 Years	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from October 25 19 55, to November 5 1955, that he was the deceased and that death occurred at 10:15 AM, from the causes and on the date stated above.							
SIGNATURE <i>William B. Vandergrift</i> WILLIAM B. VANDERGRIFF				ADDRESS (Street, city, town, state) VAH, Fort Howard, Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 11-9-55		NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. REC'D BY REGISTRAR DATE 11/4/55		REGISTRAR'S SIGNATURE <i>George G. Kelson</i> George G. Kelson		25. FUNERAL DIRECTOR'S SIGNATURE <i>George G. Kelson</i> George G. Kelson			
				ADDRESS Balto.			



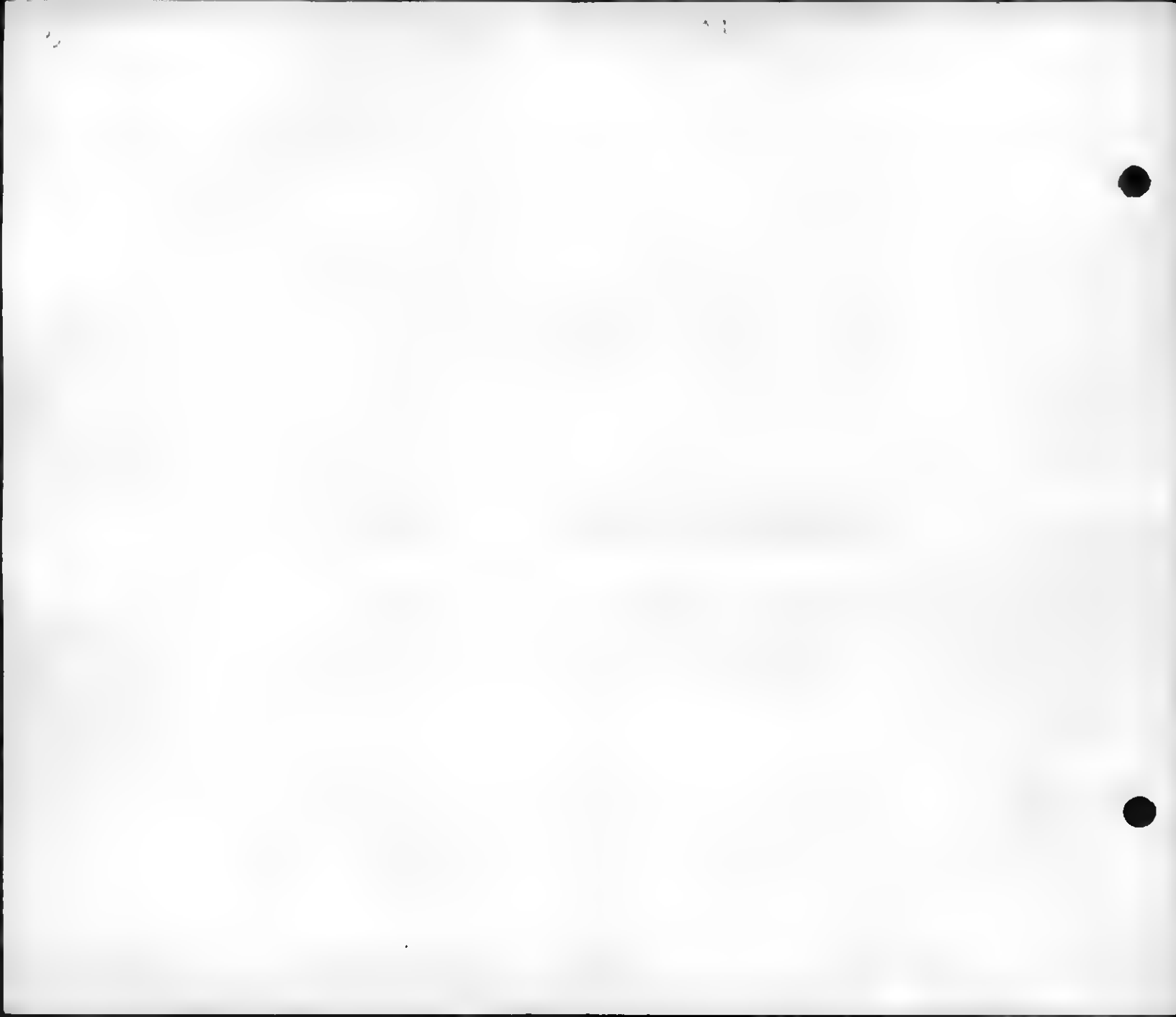
10617 CERTIFICATE OF DEATH

Reg. Dist. No. 45

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>54 Middle River</u>	LENGTH OF STAY (in this place) <u>3 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Middle River - Baltimore 20</u>	STREET ADDRESS (If rural give location) <u>1420 3rd. Rd.</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>-</u>		STREET ADDRESS <u>1420 3rd. Rd.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>KATHARINE HEINEMAN WENZEL</u>		OF DEATH: <u>NOV. 16 1955</u>	
5. SEX. <u>F.</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>	8. DATE OF BIRTH: <u>AUG. 31, 1875</u>
9. AGE last birthday: <u>80</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>-</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>-</u>	
11. BIRTHPLACE (State or foreign country): <u>Baltimore City, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John Heineman</u>		14. MOTHER'S MAIDEN NAME: <u>Marie Yingling</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>Y</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT & ADDRESS: <u>MRS FREDERICK C. ERB</u>		SAME.	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Heart insufficiency</u>			
DUE TO			
(B) <u>Coronary sclerosis, Heavy sclerosis</u>			
DUE TO			
(C) <u>of Mitral & Aort. valve,</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>JAN. 1953</u> to <u>NOV. 16, 1955</u> , that I last saw the deceased alive on <u>NOV. 16, 1955</u> , and that death occurred at <u>11:32 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Wm. J. Boulogne</u>		ADDRESS <u>M. D. ST. JOSEPH HOSPITAL</u> DATE SIGNED <u>11/16/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
BURIAL		11/19/55	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
LORRAINE PARK CEM.		WOODLAWN MARYLAND.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
11-18-55		A. W. Hedrick	
24. FUNERAL DIRECTOR		ADDRESS	
HENRY SANDER & SONS INC.		BALTIMORE MARYLAND.	



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10618

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

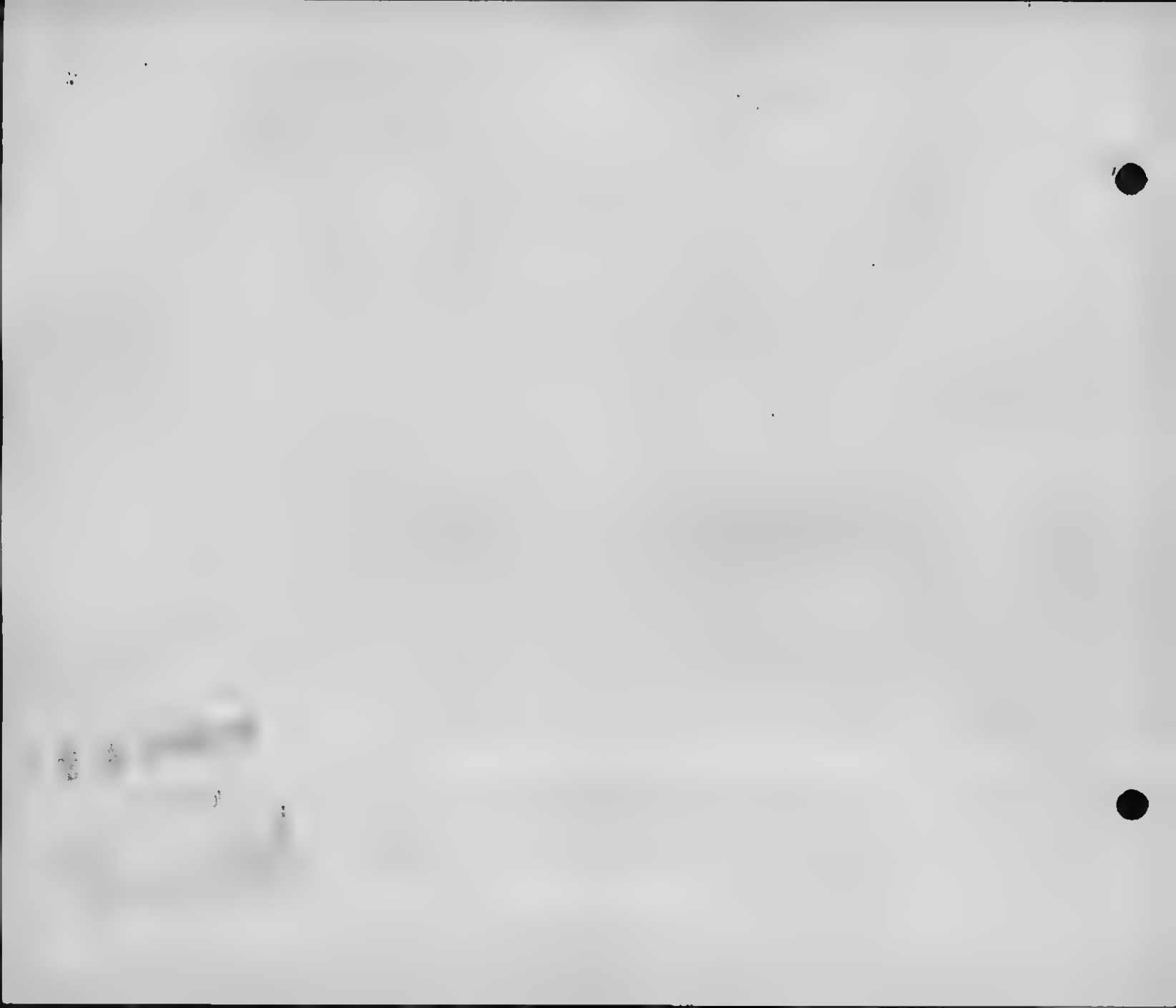
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10623

Reg. Dist.

No. 30

1. PLACE OF DEATH: COUNTY <u>Balt</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>5200 Catonsville</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Records Knoll</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>md</u> COUNTY <u>Balt</u> CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Catonsville</u> STREET ADDRESS (If rural, give location) <u>Mardenchick Lane</u>			
3. NAME OF DECEASED: (Type or Print) <u>Mary angela</u> (First) <u>Krenzing</u> (Middle) <u></u> (Last)		4. DATE OF DEATH <u>Nov 24</u> 19 <u>53</u> (Month) (Day) (Year)		5. SEX: <u>7</u> 6. COLOR OR RACE: <u>W</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>widow</u> 8. DATE OF BIRTH: <u>?</u> 9. AGE last birthday: <u>80?</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>not known</u>			
13. FATHER'S NAME: <u>not known</u>		14. MOTHER'S MAIDEN NAME: <u>not known</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u></u> (If Yes, give war or dates of <u></u>)		16. SOCIAL SECURITY No.: <u></u>		17. INFORMANT & ADDRESS: <u>Charles Krenzing</u> <u>WPA</u>			
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>422.1</u> Immediate cause (a) <u>Acute Cardiac failure</u> DUE TO Antecedent cause(s) (b) <u>Cardio vascular disease</u> DUE TO Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Smiling</u>					INTERVAL BETWEEN ONSET AND DEATH		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u></u>		19b. MAJOR FINDING OF OPERATION: <u></u>			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>Dr. McKiffer</u> <u>1010 Leede on</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Nov. 25 53</u> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>11-26-53</u>		NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem</u>			
DATE REC'D BY LOCAL REG. <u>11-26-53</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>		24. FUNERAL DIRECTOR <u>Barry Funeral Home</u> ADDRESS <u>Catonsville</u>			



10619

CERTIFICATE OF DEATH

10624

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

55

TOWN Towson

LENGTH OF STAY (in this place)

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Baltimore

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Towson

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Armacost Nursing Home
Sherwood & Regester Ave.STREET ADDRESS (If rural give location)
522 Stevenson Lane

3. NAME OF DECEASED (Type or Print)

(First) Mrs. Bertha (Middle) (Last) Wetzelberger

4. DATE OF DEATH (Month) (Day) (Year)
November 4th 19555. SEX
female6. COLOR OR RACE
white7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
married8. DATE OF BIRTH
Dec. 23, 18879. AGE last birthday
67 yrs.IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
at home

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)
Baltimore, Md12. CITIZEN OF WHAT COUNTRY?
U. S.

13. FATHER'S NAME

Louis Ritter

14. MOTHER'S MAIDEN NAME

Mandy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

Mr. Henry Wetzelberger, 522 Stevenson La.

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

442X IMMEDIATE CAUSE (A)
ANTECEDENT CAUSE(S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B)
(C)

18. MEDICAL CERTIFICATION

Cerebral Thrombosis
Hypertensive Cardio-
Renal Vascular Disease

INTERVAL BETWEEN ONSET AND DEATH

3 weeks

15 yrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 19, 1955 to Nov 4, 1955, that I last saw the deceased alive on Nov 3, 1955, and that death occurred at 6:30 AM, from the causes and on the date stated above.

SIGNATURE

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial

11/7/55

Baltimore Cemetery

Baltimore, Md

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE Nov. 4, 1955

Mabel Gray

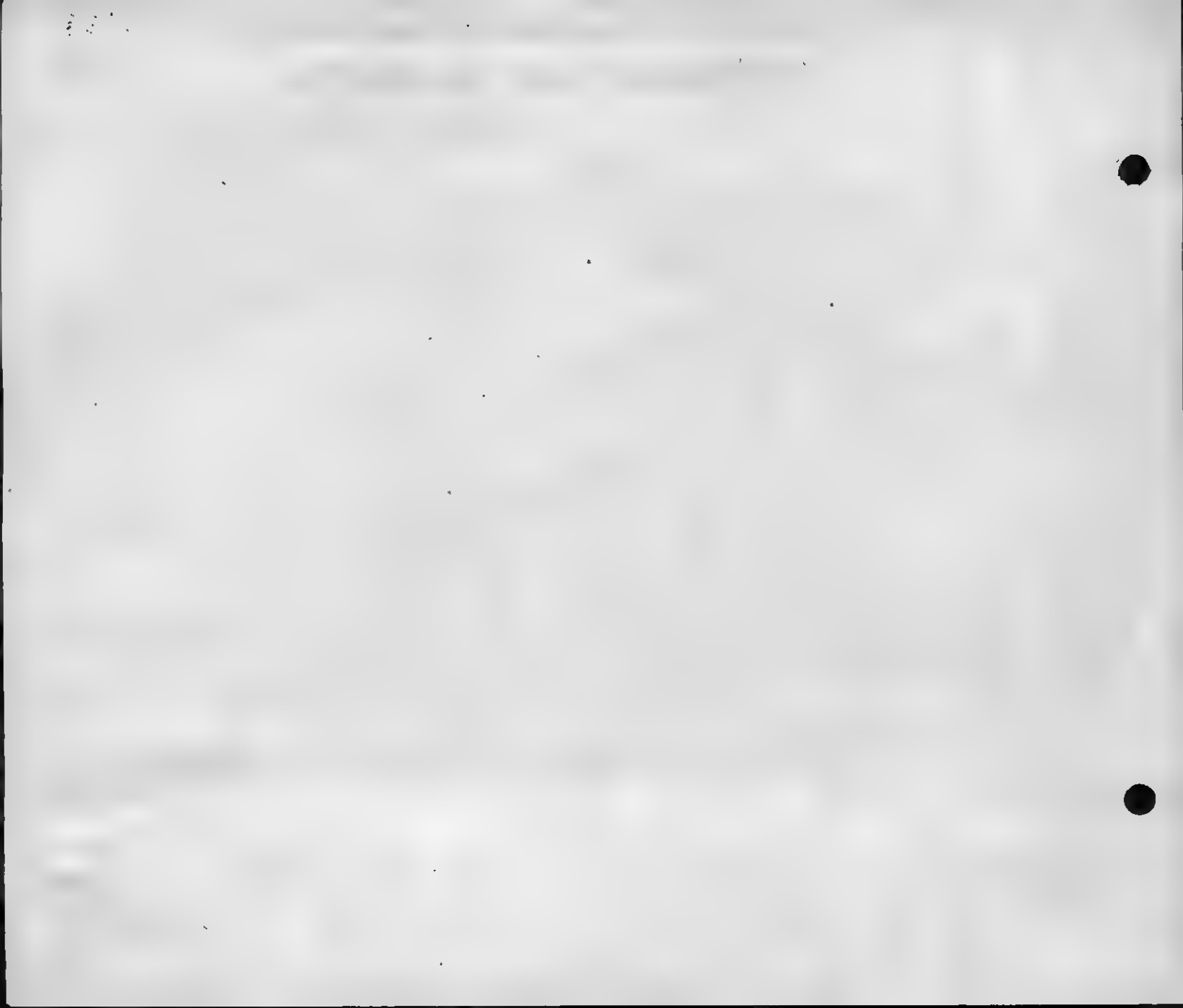
L. J. Ruck, 5305 Harford Rd, Balto

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10620 CERTIFICATE OF DEATH

10625

Reg. Dist. No. 2

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>	LENGTH OF STAY (in this place) <u>4 years</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove St. H.</u>	STREET ADDRESS (If rural give location) <u>3210 Leeds Str. Balt 29</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>William H. WHEELER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Nov 3 1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>M</u>	7. SINGLE MARRIED WIDOWED DIVORCED (Specify): <u>M</u>	8. DATE OF BIRTH: <u>2.9.1877</u>
9. AGE last birthday: <u>78</u> yrs		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Straw hat blocker</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Straw hat fact.</u>	
11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Wheeler</u>		14. MOTHER'S MAIDEN NAME: <u>Eliga</u>	
15. WAS DECEASED EVER IN U.S. ARMY OR NAVY? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Hospital records.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE		(A) <u>Cardiac failure with pulmonary emboli</u>	
ANTECEDENT CAUSE (B)		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <u>generalized arteriosclerotic C.V.D.</u>	
		DUE TO	
		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>at 10. . 1951, to Nov 3, 1955</u> , that I last saw the deceased alive on <u>Nov 3, 1955</u> , and that death occurred at <u>8 45 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Gertrude J. Fleischmann M.D.</u>		ADDRESS <u>Spring Grove St. H.</u> DATE SIGNED <u>Nov. 3. 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 17/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Faundon Park</u>		LOCATION (City, town, or county) (State) <u>Balto. Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11/4/55</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedgcock</u>	
24. FUNERAL DIRECTOR <u>Harry H. Witzke</u>		ADDRESS <u>4101 Edmondson Ave</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10626

10621 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH. COUNTY <u>Balto.</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>52</u> OR <u>TOWN</u> <u>Catonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7 Woodlawn Ave.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>Balto.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>52</u> OR <u>TOWN</u> <u>Catonsville</u> STREET ADDRESS (If rural give location) <u>7 Woodlawn Ave.</u>	
3. NAME OF DECEASED: (Type or Print) <u>LETTIE</u> (First) <u>M.</u> (Middle) <u>WHIP</u> (Last)		4. DATE (Month) (Day) (Year) OF DEATH. <u>Nov.</u> <u>16</u> , 19 <u>55</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH. <u>April 5, 1859</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>--</u>		10B. KIND OF BUSINESS OR INDUSTRY. <u>--</u>	
11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>--</u>	
13. FATHER'S NAME: <u>William Culler</u>		14. MOTHER'S MAIDEN NAME: <u>Minerva Hawker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.1</u> IMMEDIATE CAUSE ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>(A) Anteriorischemic cardiovascular disease</u> DUE TO <u>(B) --</u> DUE TO <u>(C) --</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs +</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>--</u>		19B. MAJOR FINDINGS OF OPERATION <u>--</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb</u>, 19<u>52</u> to <u>Nov. 16</u>, 19<u>55</u>, that I last saw the deceased alive on <u>Nov. 15</u>, 19<u>55</u>, and that death occurred at <u>4:25 PM</u>, from the causes and on the date stated above.			
SIGNATURE <u>Jahna Hester</u>		ADDRESS <u>M. D. 1118 St Paul St. Balt. 2 Ind</u>	
DATE SIGNED <u>11-16-55</u>		23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	
DATE THEREOF <u>11/19/55</u>		NAME OF CEMETERY OR CREMATORY <u>Jefferson Lutheran Cem.</u>	
LOCATION (City, town, or county) (State) <u>Jefferson, Md.</u>		24. FUNERAL DIRECTOR <u>Wm. J. Dickerson & Sons - Balt. Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11/17/55</u>		REGISTRAR'S SIGNATURE <u>--</u>	



1

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

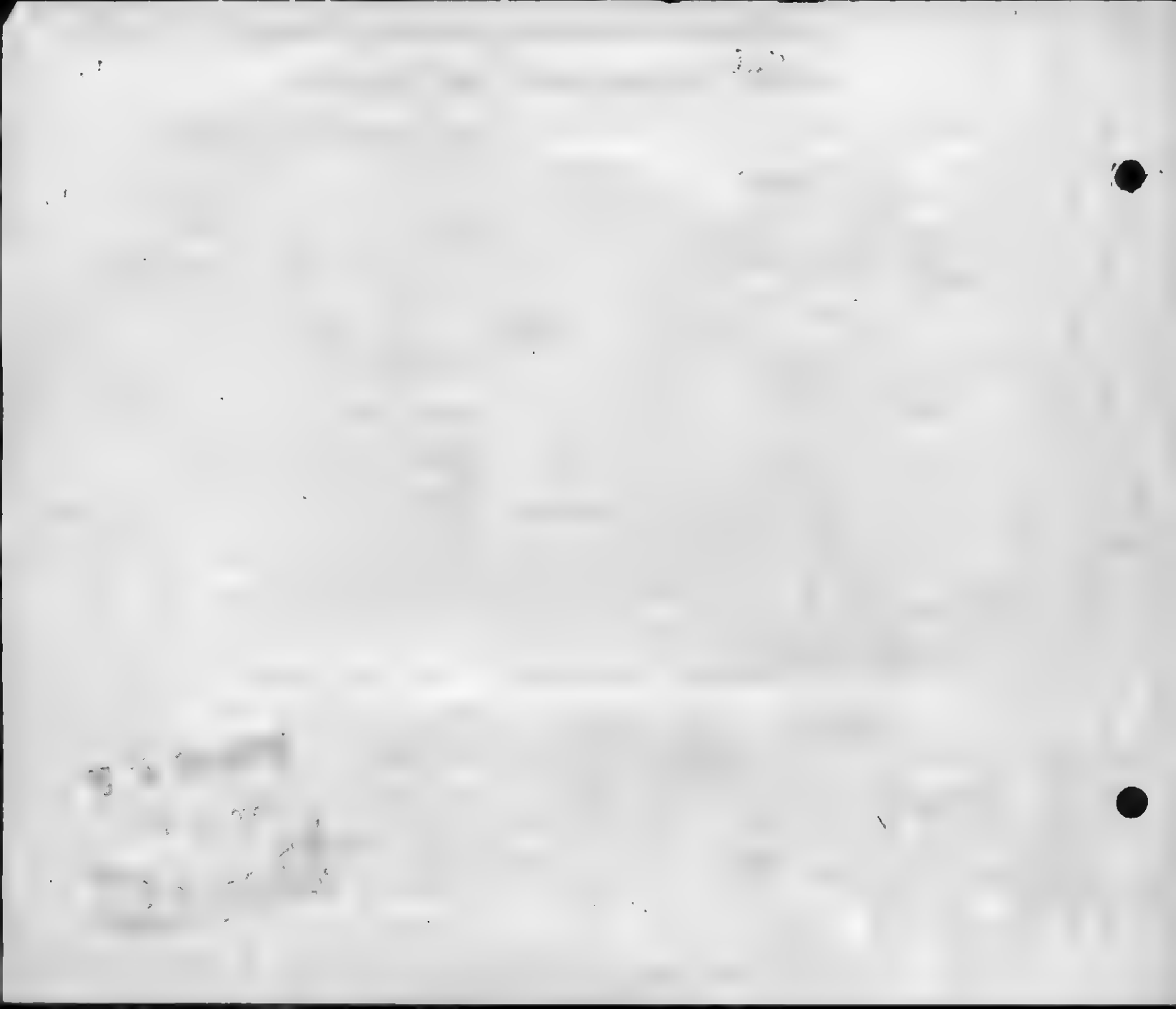
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10627

10459 CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>10NDALK 22</u>		LENGTH OF STAY (in this place) <u>35 YRS.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>10NDALK 22</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8 PORTSHIP Rd</u>				STREET ADDRESS (If rural give location) <u>8 PORTSHIP Rd</u>			
3. NAME OF DECEASED (Type or Print) <u>ROSETTA M. CCKENHOUSE WIEAND</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>11-28-1955</u>			
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>25 APRIL 1890</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ M.n. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOMIE</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>CHARLES CCKENHOUSE</u>				14. MOTHER'S MAIDEN NAME <u>ROSA. LECHLEIR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT & ADDRESS <u>WILMER E. WIEAND - SAME</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
170X IMMEDIATE CAUSE (A) <u>CARCINOMA OF RT. BREAST C.</u>						<u>5 yrs +</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Metastases</u>						<u>6 mos</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19. DATE OF OPERATION <u>MAY-1951</u>		19b. MAJOR FINDINGS OF OPERATION <u>Liver</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Home</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>51</u> , to <u>Nov. 28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov. 27</u> , 19 <u>55</u> , and that death occurred at <u>4 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Mrs Davis</u>		DATE THEROF <u>12-1-55</u>		NAME OF CEMETERY OR CREMATORY <u>GREAT SWAMP REF. CHURCH</u>		LOCATION (City, town, or county) (State) <u>SPINNERSTOWN, PA.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24. REC'D BY REGISTRAR <u>William M. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brock Penally, Dundalk, Md.</u>		ADDRESS	
DATE <u>Nov 30-1955</u>							



1

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

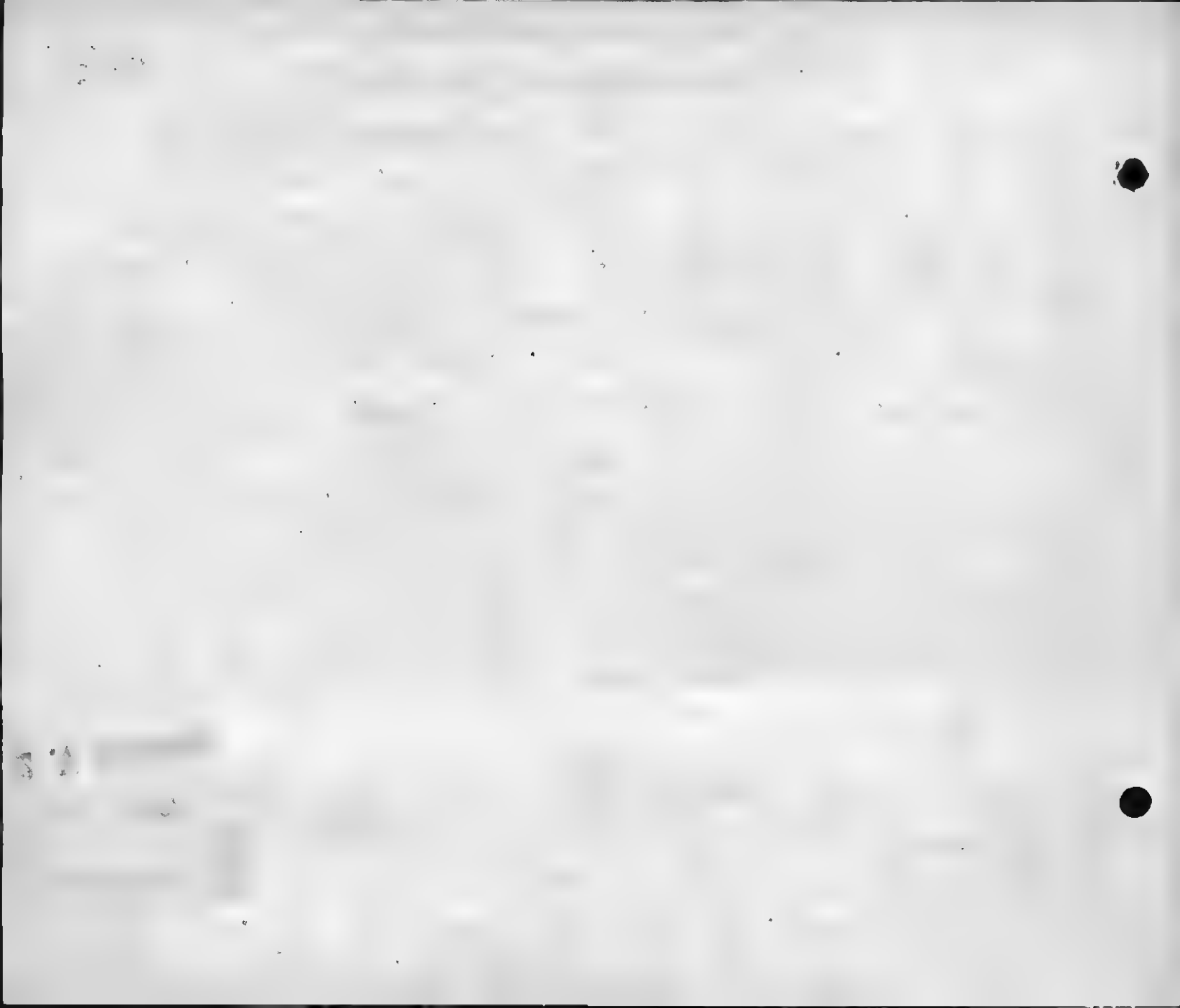
10622

CERTIFICATE OF DEATH

10628

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>MD</u> COUNTY <u>Balto.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Arrisonville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Arrisonville</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Arrisonville</u>		LENGTH OF STAY (In this place) <u>4 yrs</u>		TOWN <u>Arrisonville</u>		TOWN <u>Arrisonville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Arrisonville, Md.</u>				STREET ADDRESS (If rural give location) <u>Arrisonville, Md.</u>			
3. NAME OF DECEASED (Type or Print) <u>James H. Wigley</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 26, 1955</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Jan. 19, 1860</u>	9. AGE last birthday <u>95</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>O.H.</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Weckesser</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>?</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT & ADDRESS <u>Dr. Bartus B. Wigley, 4231 Flower St. 2d.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>442X</u> IMMEDIATE CAUSE (A) <u>ACUTE CONGESTIVE HEART FAILURE</u>						<u>3 DAYS</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>HYPERTENSIVE C.V. DISEASE & SEVERE</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>KIDNEY DAMAGE</u>						<u>10 YEARS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>APRIL 1, 1953</u> , to <u>NOV. 26, 1955</u> , that I last saw the deceased alive on <u>NOV. 26, 1955</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Thomas E. L. L. L.</u>		M.D. <u>7401 Cephalopod - Baltimore</u>		DATE SIGNED <u>1/27/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 29/55</u>		NAME OF CEMETERY OR CREMATORY <u>Donor Park</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. REC'D BY REGISTRAR <u>Nov. 27, 1955</u>		REGISTRAR'S SIGNATURE <u>Dr. J. M. D. Martin</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witzke</u>		ADDRESS <u>101 London Ave</u>	



1

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10623

CERTIFICATE OF DEATH

10629

Reg. Dist. No. 30

Items # 91 Film 189 11/25/55

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		STATE MARYLAND		COUNTY Baltimore			
CITY (If outside corporate limits, write RURAL or give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
52 TOWN Catonsville		10 yrs.		52 TOWN Catonsville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
406 Forest Lane				406 Forest Lane			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) CALVIN (Middle) SWANN (Last) WILEY				(Month) November (Day) 15 (Year) 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Married	September 14, 1911	44 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Electrical Technetion			Totaling Machines		Virginia		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Thomas Wiley				Gertrude Carroll			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
Yes		W.W. 2		406 Forest Lane			
		219-01-3740		Mrs. Margaret Wiley Catonsville 28, Md.			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) ACUTE CORONARY OCCLUSION						30 minutes	
ANTECEDENT CAUSE(S) DUE TO (B) CORONARY ARTERY DISEASE WITH PREVIOUS CORONARY OCCLUSION						3 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work Not white at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 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2774, 2775, 2776, 2777, 2778, 2779, 2780, 2781, 2782, 2783, 2784, 2785, 2786, 2787, 2788, 2789, 2790, 2791, 2792, 2793, 2794, 2795, 2796, 2797, 2798, 2799, 2800, 2801, 2802, 2803, 2804, 2805, 2806, 2807, 2808, 2809, 2810, 2811, 2812, 2813, 2814, 2815, 2816, 2817, 2818, 2819, 2820, 2821, 2822, 2823, 2824, 2825, 2826, 2827, 2828, 2829, 2830, 2831, 2832, 2833, 2834, 2835, 2836, 2837, 2838, 2839, 2840, 2841, 2842, 2843, 2844, 2845, 2846, 2847, 2848, 2849, 2850, 2851, 2852, 2853, 2854, 2855, 2856, 2857, 2858, 2859, 2860, 2861, 2862, 2863, 2864, 2865, 2866, 2867, 2868, 2869, 2870, 2871, 2872, 2873, 2874, 2875, 2876, 2877, 2878, 2879, 2880, 2881, 2882, 2883, 2884, 2885, 2886, 2887, 2888, 2889, 2890, 2891, 2892, 2893, 2894, 2895, 2896, 2897, 2898, 2899, 2900, 2901, 2902, 2903, 2904, 2905, 2906, 2907, 2908, 2909, 2910, 2911, 2912, 2913, 2914, 2915, 2916, 2917, 2918, 2919, 2920, 2921, 2922, 2923, 2924, 2925, 2926, 2927, 2928, 2929, 2930, 2931, 2932, 2933, 2934, 2935, 2936, 2937, 2938, 2939, 2940, 2941, 2942, 2943, 2944, 2945, 2946, 2947, 2948, 2949, 2950, 2951, 2952, 2953, 2954, 2955, 2956, 2957, 2958, 2959, 2960, 2961, 2962, 2963, 2964, 2965, 2966, 2967, 2968, 2969, 2970, 2971, 2972, 2973, 2974, 2975, 2976, 2977, 2978, 2979, 2980, 2981, 2982, 2983, 2984, 2985, 2986, 2987, 2988, 2989, 2990, 2991, 2992, 2993, 2994, 2995, 2996, 2997, 2998, 2999, 3000, 3001, 3002, 3003, 3004, 3005, 3006, 3007, 3008, 3009, 3010, 3011, 3012, 3013, 3014, 3015, 3016, 3017, 3018, 3019, 3020, 3021, 3022, 3023, 3024, 3025, 3026, 3027, 3028, 3029, 3030, 3031, 3032, 3033, 3034, 3035, 3036, 3037, 3038, 3039, 3040, 3041, 3042, 3043, 3044, 3045, 3046, 3047, 3048, 3049, 3050, 3051, 3052, 3053, 3054, 3055, 3056, 3057, 3058, 3059, 3060, 3061, 3062, 3063, 3064, 3065, 3066, 3067, 3068, 3069, 3070, 3071, 3072, 3073, 3074, 3075, 3076, 3077, 3078, 3079, 3080, 3081, 3082, 3083, 3084, 3085, 3086, 3087, 3088, 3089, 3090, 3091, 3092, 3093, 3094, 3095, 3096, 3097, 3098, 3099, 3100, 3101, 3102, 3103, 3104, 3105, 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3272, 3273, 3274, 3275, 3276, 3277, 3278, 3279, 3280, 3281, 3282, 3283, 3284, 3285, 3286, 3287, 3288, 3289, 3290, 3291, 3292, 3293, 3294, 3295, 3296, 3297, 3298, 3299, 3300, 3301, 3302, 3303, 3304, 3305, 3306, 3307, 3308, 3309, 3310, 3311, 3312, 3313, 3314, 3315, 3316, 3317, 3318, 3319, 3320, 3321, 3322, 3323, 3324, 3325, 3326, 3327, 3328, 3329, 3330, 3331, 3332, 3333, 3334, 3335, 3336, 3337, 3338, 3339, 3340, 3341, 3342, 3343, 3344, 3345, 3346, 3347, 3348, 3349, 3350, 3351, 3352, 3353, 3354, 3355, 3356, 3357, 3358, 3359, 3360, 3361, 3362, 3363, 3364, 3365, 3366, 3367, 3368, 3369, 3370, 3371, 3372, 3373, 3374, 3375, 3376, 3377, 3378, 3379, 3380, 3381, 3382, 3383, 3384, 3385, 3386, 3387, 3388, 3389, 3390, 3391, 3392, 3393, 3394, 3395, 3396, 3397, 3398, 3399, 3400, 3401, 3402, 3403, 3404, 3405, 3406, 3407, 3408, 3409, 3410, 3411, 3412, 3413, 3414, 3415, 3416, 3417, 3418, 3419, 3420, 3421, 3422, 3423, 3424, 3425, 3426, 3427, 3428, 3429, 3430, 3431, 3432, 3433, 3434, 3435, 3436, 3437, 3438, 3439, 3440, 3441, 3442, 3443, 3444, 3445, 3446, 3447, 3448, 3449, 3450, 3451, 3452, 3453, 3454, 3455, 3456, 3457, 3458, 3459, 3460, 3461, 3462, 3463, 3464, 3465, 3466, 3467, 3468, 3469, 3470, 3471, 3472, 3473, 3474, 3475, 3476, 3477, 3478, 3479, 3480, 3481, 3482, 3483, 3484, 3485, 3486, 3487, 3488, 3489, 3490, 3491, 3492, 3493, 3494, 3495, 3496, 3497, 3498, 3499, 3500, 3501, 3502, 3503, 3504, 3505, 3506, 3507, 3508, 3509, 3510, 3511, 3512, 3513, 3514, 3515, 3516, 3517, 3518, 3519, 3520, 3521, 3522, 3523, 3524, 3525, 3526, 3527, 3528, 3529, 3530, 3531, 3532, 3533, 3534, 3535, 3536, 3537, 3538, 3539, 3540, 3541, 3542, 3543, 3544, 3545, 3546, 3547, 3548, 3549, 3550, 3551, 3552, 3553, 3554, 3555, 3556, 3557, 3558, 3559, 3560, 3561, 3562, 3563, 3564, 3565, 3566, 3567, 3568, 3569, 3570, 3571, 3572, 3573, 3574, 3575, 3576, 3577, 3578, 3579, 3580, 3581, 3582, 3583, 3584, 3585, 3586, 3587, 3588, 3589, 3590, 3591, 3592, 3593, 3594, 3595, 3596, 3597, 3598, 3599, 3600, 3601, 3602, 3603, 3604, 3605, 3606, 3607, 3608, 3609, 3610, 3611, 3612, 3613, 3614, 3615, 3616, 3617, 3618, 3619, 3620, 3621, 3622, 3623, 3624, 3625, 3626, 3627, 3628, 3629, 3630, 3631, 3632, 3633, 3634, 3635, 3636, 3637, 3638, 3639, 3640, 3641, 3642, 3643, 3644, 3645, 3646, 3647, 3648, 3649, 3650, 3651, 3652, 3653, 3							



10624 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>York</u>	
CITY (If outside corporate limits, write OR and give nearest town) <u>Balto</u>		LENGTH OF STAY (in this place) <u>25 yr.</u>		CITY (If outside corporate limits, write OR and give nearest town) <u>Balto</u>		Y	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Oakmont Ave.</u>				STREET ADDRESS (If rural give location) <u>Oakmont Ave</u>			
3. NAME OF DECEASED: (First) <u>Kathryn</u> (Middle) <u>Virginia</u> (Last) <u>Helmer</u>				4. DATE OF DEATH: (Month) <u>Nov</u> (Day) <u>3</u> (Year) <u>1955</u>			
5. SEX: <u>57</u>		6. COLOR OR RACE: <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Mar.</u>		8. DATE OF BIRTH: <u>Sept. 21, 1904</u>	
9. AGE last birthday: <u>51</u> yrs.		10. UNDER 1 YEAR		11. UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>House</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State of foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Nachary, Nathan</u>				14. MOTHER'S MAIDEN NAME: <u>Michael Mrs. J.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>C</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Frank, Oakmont Ave Balto</u>	

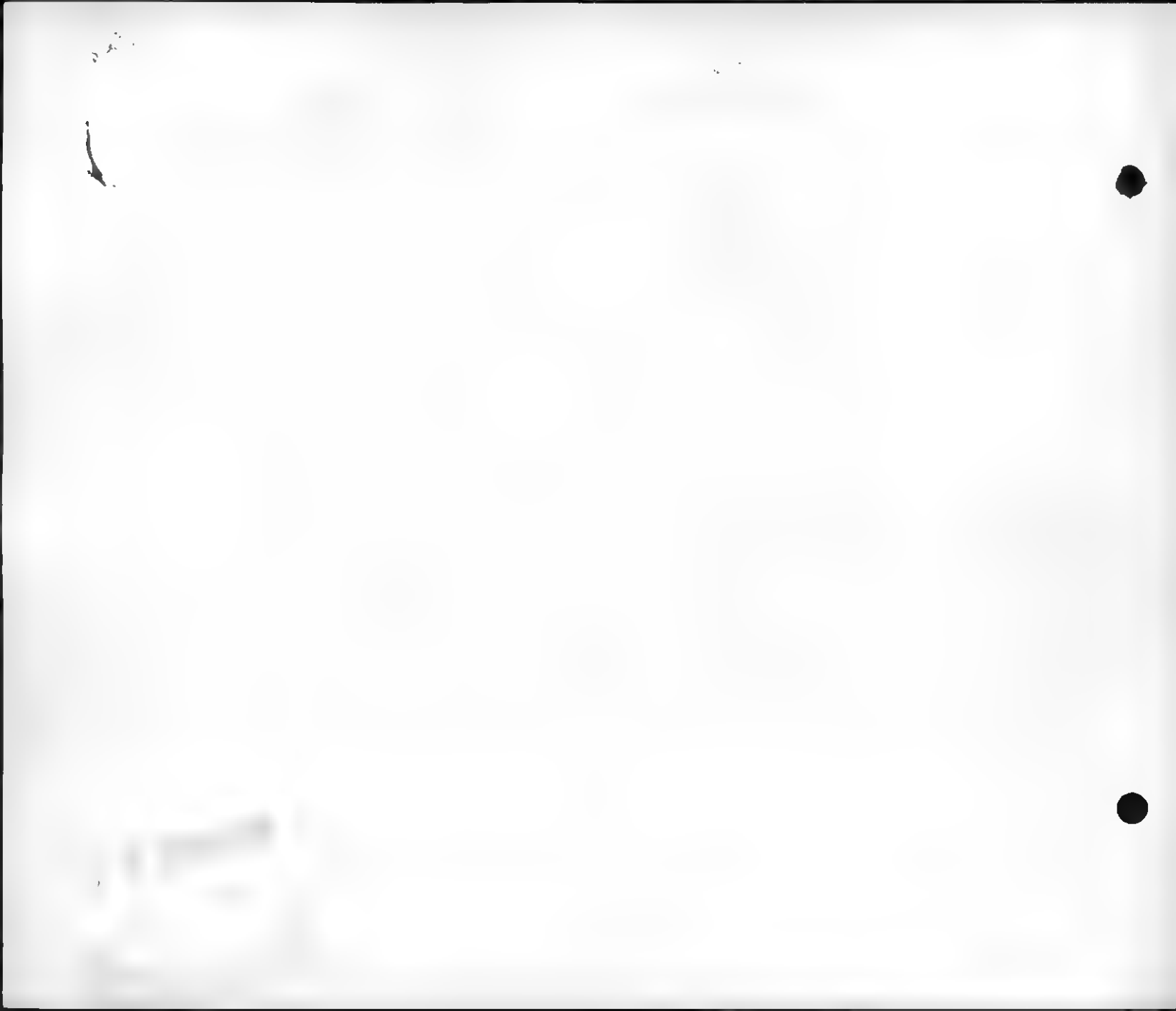
18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>179X</u>	DUE TO <u>Leucites and leukin</u>	<u>8 wks.</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(b) <u>Generalized Carcinoma</u>	<u>1 yr.</u>
	(c) <u>Breast Car.</u>	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>			
19a. DATE OF OPERATION: <u>Nov 1952</u>		19b. MAJOR FINDINGS OF OPERATION: <u>Ca. Breast</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify): <u>None</u>		PLACE (Home, farm, factory, street, office bldg., etc.): <u>None</u>	
TIME (Month) (Day) (Year) (Hour) <u>None</u>		INJURY OCCURRED White at Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR? <u>None</u>			

22. I hereby certify that I attended the deceased from <u>Nov 1, 1955</u> , to <u>Nov 3, 1955</u> , that I last saw the deceased alive on <u>Nov 1, 1955</u> , and that death occurred at <u>4:45 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Frank J. Kase</u>		DATE SIGNED <u>Nov 3, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Nov 6, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>New Freedom Cemetery</u>		LOCATION (City, town, or county) (State) <u>New Freedom, York Co. Pa.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11/4/55</u>		REGISTRAR'S SIGNATURE <u>D.M. Bacon</u>	
24. FUNERAL DIRECTOR <u>Jacob Hartenstein</u>		ADDRESS <u>New Freedom, Pa.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



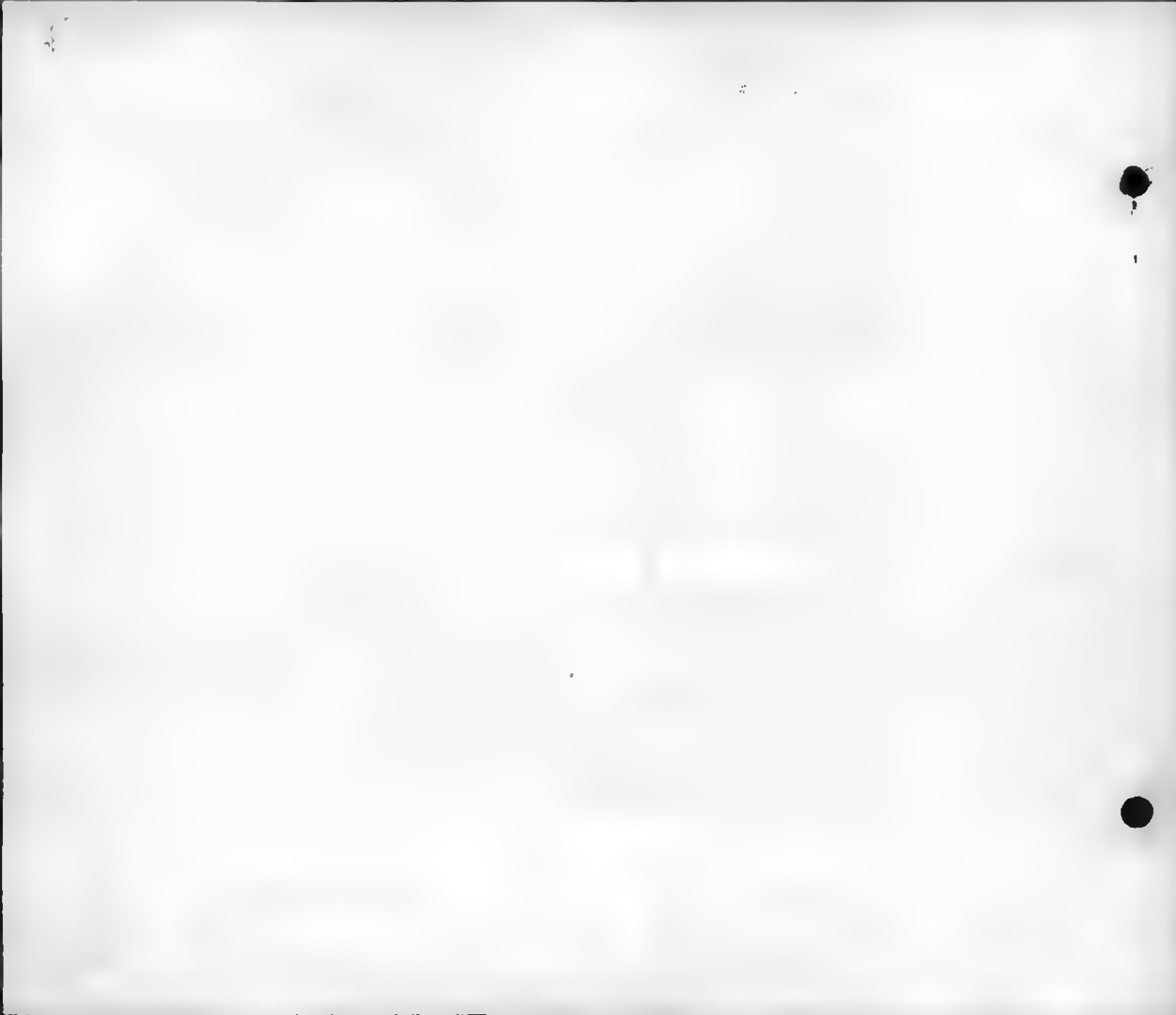
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10631
10625 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 TOWN</u>	LENGTH OF STAY (in this place) <u>12 years</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>123 Hunters Lane</u>		STREET ADDRESS (If rural give location) <u>123 Hunters Lane</u>	
3. NAME OF DECEASED: (Type or Print) <u>Claude</u> (First) <u>Williams</u> (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <u>Nov. 6</u> 19 <u>55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, OR SEPARATED: <u>Widowed</u>	8. DATE OF BIRTH: <u>Oct. 18, 1871</u>
9. AGE last birthday <u>84</u> yrs.		10. AGE last birthday IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Barber</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Barber shop</u>	
11. BIRTHPLACE (State or foreign country): <u>Salina, Kansas</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Unknown</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S NAME: <u>Mrs. Mary Owens</u>		18. ADDRESS: <u>123 Hunters Lane</u>	
19. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Mitral Insufficiency</u>			<u>56 Days</u>
ANTECEDENT CAUSE (B) <u>Arterio-Sclerotic Heart Disease</u>			<u>?</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chr. Arthritis</u>			<u>?</u>
19A. DATE OF OPERATION: <u>C</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-11-55</u> , 19 <u>55</u> , to <u>11-6-55</u> 19 <u>55</u> , that I last saw the deceased alive on <u>11-6-55</u> , 19 <u>55</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>C. F. Maloney</u>		DATE SIGNED <u>11-6-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 10, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Pk.</u>		LOCATION (City, town, or county) (State) <u>Baltimore Co., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11/10/55</u>		REGISTRAR'S SIGNATURE <u>A. W. Fitch</u>	
FUNERAL DIRECTOR <u>1631 Smith & Hill Co.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH: *Baltimore*
COUNTY *877 Doalou Are* MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) LENGTH OF STAY
OR (In this place)
TOWN *Balto 22 - Dundalk*
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE *Md.* COUNTY *F*
CITY (If outside corporate limits, write RURAL and give nearest town)
OR TOWN *Balto. 22*
STREET ADDRESS (If rural give location)
877 Doalou Are

3. NAME OF DECEASED: (Type or Print) *Emma M. Williams*
First (Middle) (Last)
4. DATE (Month) (Day) (Year)
OF DEATH: *Nov. 29 1958*

5. SEX: *Female* 6. COLOR OR RACE: *White* 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) *Widowed* 8. DATE OF BIRTH: *Sept 24-1892* 9. AGE last birthday *63* yrs Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *School Teacher. Retired.* 10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): *Georgia* 12. CITIZEN OF WHAT COUNTRY? *U.S.A*

13. FATHER'S NAME: *Benjamin Morrison* 14. MOTHER'S MAIDEN NAME: *Unknown*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT & ADDRESS: *Harry W. Williams 877 Doalou Are*

18. MEDICAL CERTIFICATION
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
199.5 IMMEDIATE CAUSE (A) *Metoplastic Ca - to Brain*
ANTECEDENT CAUSE (S): DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST DUE TO (B) *Carcinomatous - generalized*
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLY NG ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE (Home, farm, factory street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M. 21E. INJURY OCCURRED While ☐ Not while ☐ at work at work 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *October 1955*, to *Nov 24/58*, that I last saw the deceased alive on *Nov 20/58*, and that death occurred at *11 PM*, from the causes and on the date stated above.
SIGNATURE *Donald Benin* M. D. ADDRESS *11/29/58*

23. BURIAL, CREMATION, REMOVAL (SPECIFY) *Removal* DATE THEREOF *11-30-58* NAME OF CEMETERY OR CREMATORY *Graville* LOCATION (City, town, or county) (State) *North Carolina*

DATE REC'D BY LOCAL REGISTRAR *DEC 2 - 1958* REGISTRAR'S SIGNATURE *W. Williams* 24. FUNERAL DIRECTOR ADDRESS *1217 St Paul St.*

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10632

10626 **CERTIFICATE OF DEATH**

Item 1, File 11-3-55 et

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY BALTIMORE		STATE MARYLAND		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN FORT HOWARD		33 days		TOWN BERLIN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL				STREET ADDRESS (If rural give location) BROAD STREET			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
ALFRED H. WILLIS				November 1, 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	WHITE	WIDOWED	6-8-86	69 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		11. BIRTHPLACE (State or foreign country) BERLIN, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES WILLIS				14. MOTHER'S MAIDEN NAME DELIA QUILLIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) YES		16. SOCIAL SECURITY NO. 218-14-4119		17. INFORMANT & ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				5 WEEKS			
4201 IMMEDIATE CAUSE (A) ARTERIOSCLEROTIC CORONARY THROMBOSIS							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH PNEUMONIA				10 DAYS			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 29, 1955, to November 1, 1955, and that death occurred at 2:30 PM, from the causes and on the date stated above.							
SIGNATURE JOHN A. SURMONTE				ADDRESS (Street, city, town, state) M.D., VAH, Fort Howard, Maryland		DATE SIGNED 11-1-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 11-3-55		NAME OF CEMETERY OR CREMATORY ST. PAULS CEMETERY		LOCATION (City, town, or county) BERLIN, MARYLAND	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Dawson L. Farley		25. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc.			
DATE				1900 Eutaw Place, Baltimore, Md.			



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10633

10627 CERTIFICATE OF DEATH

Reg. Dist. No. 30

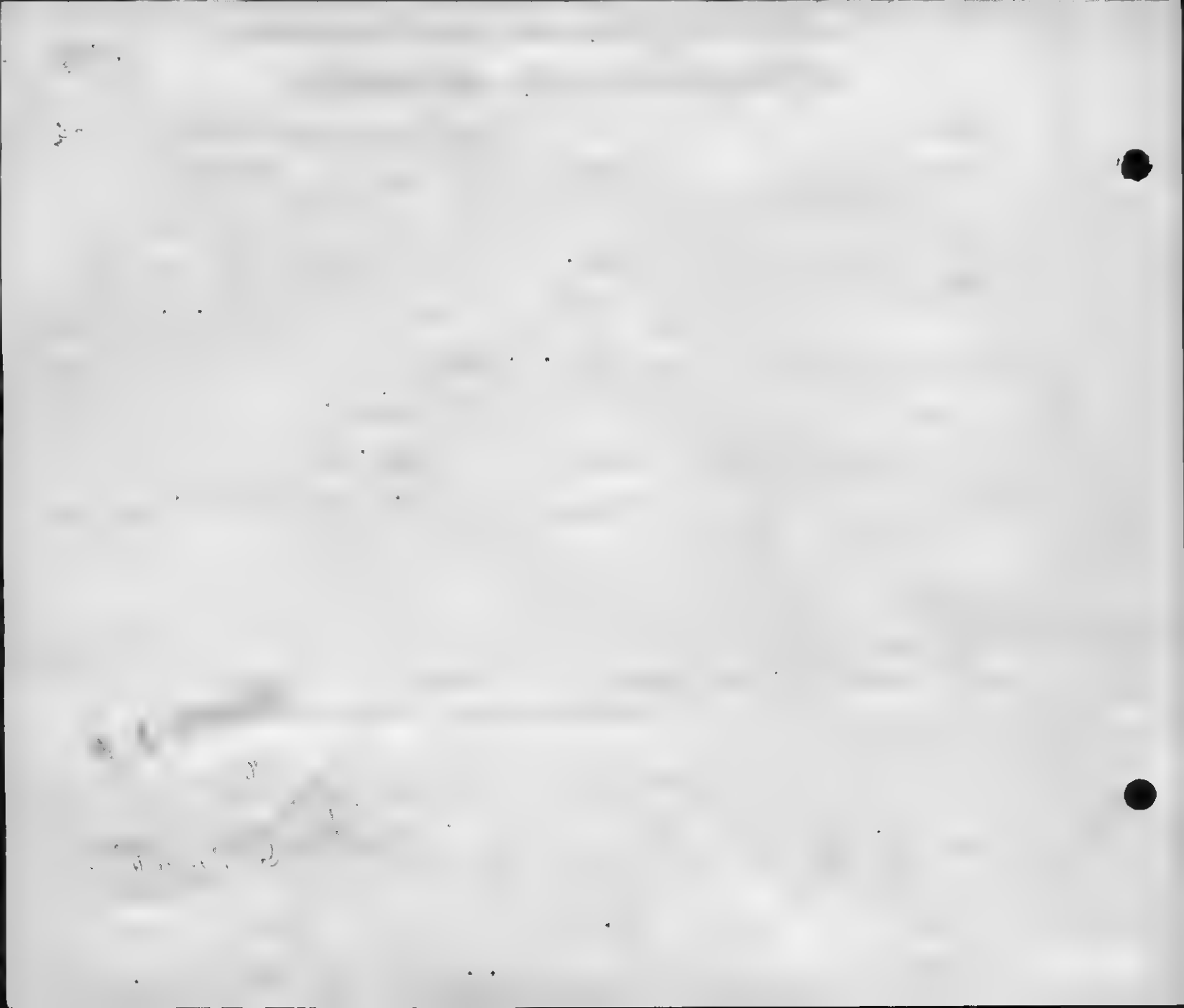
INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>53</u> TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>		<u>53</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in Pines, Fusting Ave.</u>				STREET ADDRESS (If rural give location) <u>504 Dorchester Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ELLEN</u> (Middle) <u>ARNOLD</u> (Last) <u>WILSON</u>				(Month) <u>Nov.</u> (Day) <u>19</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. CO. OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 21, 1891</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Wesley Hillsinger</u>				14. MOTHER'S MAIDEN NAME <u>Margaret C. Kraft</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT & ADDRESS <u>Harry S. Wilson, Catonsville, Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>26</u> x IMMEDIATE CAUSE (A) <u>acute posterior myocardial infarction</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) <u>Diabetes mellitus</u>							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 15</u> , 19 <u>50</u> , to <u>Nov. 19</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov. 19</u> , 19 <u>55</u> , and that death occurred at <u>11:40</u> M., from the causes and on the date stated above.							
SIGNATURE <u>George J. Higinbotham</u>		M.D.		ADDRESS (Street, city, town, state) <u>1113 31 and 11 1/2 Ave. N.E., N.E. 11</u>		DATE SIGNED <u>Nov. 21, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>11-22-55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		LOCATION (City, town, or county) (State) <u>Ellicott City, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>J.E. Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham, Ellicott City, Md.</u>			
DATE <u>11-22-55</u>							



10634

10628 CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>Id</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Baltimore</u>		<u>Life</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Trump Mill Rd</u>				STREET ADDRESS (If rural give location) <u>Box 312 Trump Mill Rd.</u>			
3. NAME OF DECEASED (Type or Print) <u>Alvin J. Wolf</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 5 1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 2-1898</u>	9. AGE last birthday <u>57</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John C. Volz</u>				14. MOTHER'S MAIDEN NAME <u>Anelia Schaub</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>John G. Wolf Trump Mill Rd</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
18a. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
47.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>				<u>Sudden</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic CardioVascular disease</u>				<u>2 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1</u> , 19 <u>55</u> , to <u>Nov 5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov 5</u> , 19 <u>55</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>M. Baumgardner</u> M.D.				ADDRESS (Street, city, town, state) <u>Balto Md</u>		DATE SIGNED <u>11/5/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/8/55</u>		NAME OF CEMETERY OR CREMATORY <u>Zion Luth Cen.</u>		LOCATION (City, town, or county) (State) <u>Balto Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mrs. A. L. ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Lassell Funeral Home</u>		ADDRESS <u>7401 Belam Rd.</u>	
DATE <u>Nov. 9, 1955</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled in by the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



10629

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL) OR TOWN <u>52 Catonsville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6032 Edmondson Ave.</u>		STREET ADDRESS (If rural give location) <u>6032 Edmondson Ave.</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year)	
First (Middle) (Last) <u>WILBUR S. YOST</u>		OF DEATH: <u>Nov. 21, 19 55</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Mar. 4, 1879</u>
9. AGE last birthday <u>76</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>retired repairman</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>retired repairman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Leather goods</u>	
11. FATHER'S NAME: <u>Samuel Yost</u>		12. CITIZEN OF WHAT COUNTRY? <u>Md.</u>	
13. MOTHER'S MAIEN NAME: <u>Almira Fishburn</u>		14. INFORMANT & ADDRESS: <u>Mrs. Anna J. Yost-6032 Edmondson Ave.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-07-2137</u>	
17. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
434.1 IMMEDIATE CAUSE			
ANTECEDENT CAUSE (S):			
DISEASES OR CONOITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic catarrh of the heart</u>			
19A. DATE OF OPERATION: <u>01</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory) OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>20</u> , 19 <u>55</u> , to <u>22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>for 20</u> , 19 <u>55</u> , and that death occurred at <u>4:15 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>Nov 21 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/23/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11-23-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>Balto 17</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 7 days after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

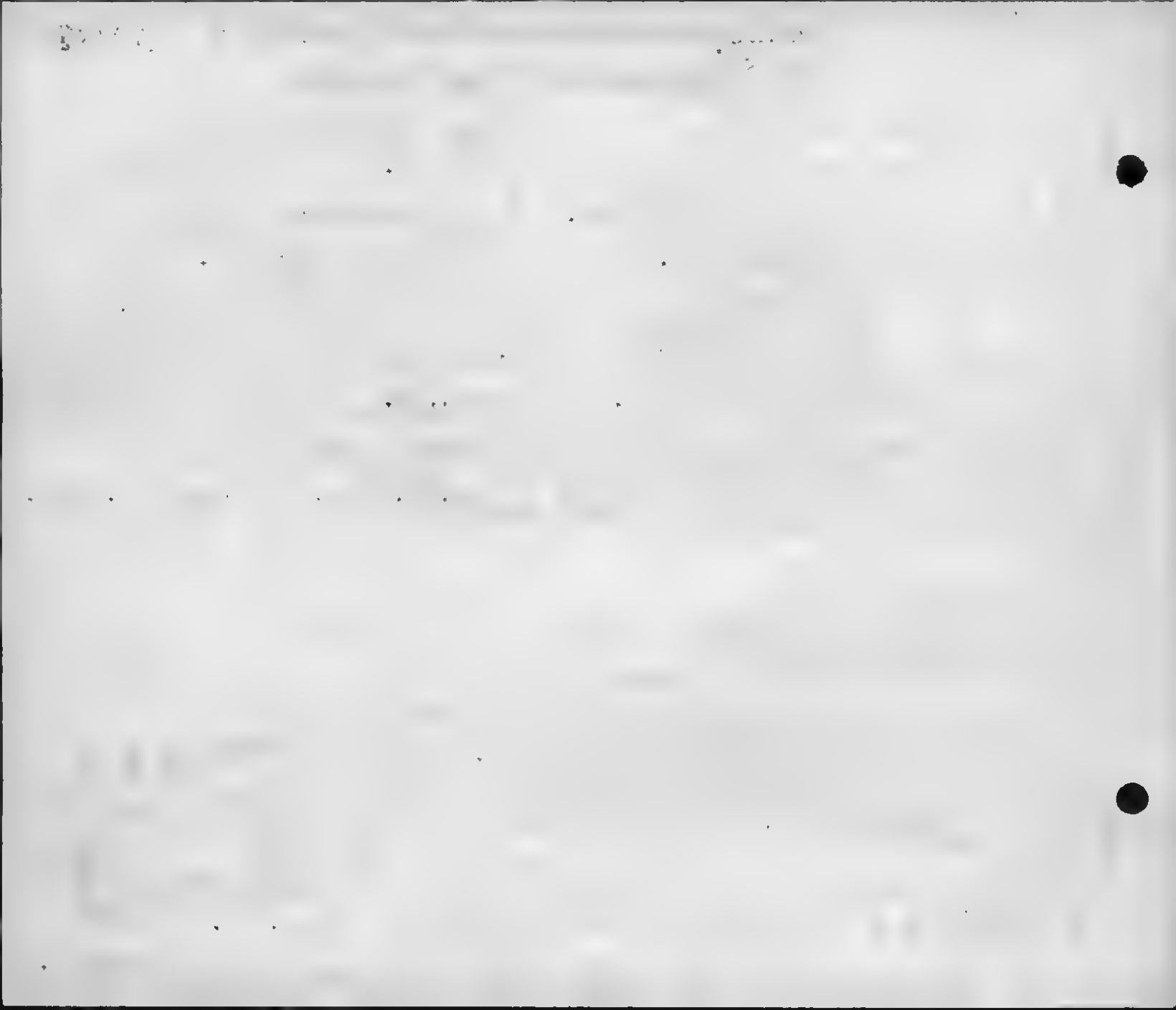
10636

10630

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Raspeburg</u>		<u>35 yrs.</u>		TOWN <u>Raspeburg</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>4601 Kenwood Ave.</u>				<u>4601 Kenwood Ave.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>HERBERT ZABEL</u>				<u>November 4, 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>male</u>	<u>white</u>	<u>married</u>	<u>May 27, 1893</u>	<u>62 yrs.</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Salesman</u>		<u>Paint Co.</u>		<u>Balto., Md.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Charles Zabel</u>				<u>Margaret Swartz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>				<u>Mr. Wm. Zabel, 1-A Glenmore Ave., Balto. 6</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
4. IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<u>CORONARY THROMBOSIS</u>						<u>3 hr.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST.							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 28, 1948, to Nov. 4, 1955, that I last saw the deceased alive on Nov. 4, 1955, and that death occurred at 12:40 P.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Adam G. Lewis</u>				<u>Nov. 5, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				24. REC'D BY REGISTRAR			
<u>burial</u>				<u>Nov. 9, 1955</u>			
DATE THEREOF				NAME OF CEMETERY OR CREMATORY			
<u>11/7/55</u>				<u>Parkwood Cemetery</u>			
REGISTRAR'S SIGNATURE				LOCATION (City, town, or county)			
<u>Wm. A. L. Reysner</u>				<u>Balto., Md.</u>			
25. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS			
<u>Lorraine Funeral Home</u>				<u>7401 Belair Rd.</u>			



10631 CERTIFICATE OF DEATH

Reg. Dist. No. 30

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Catonsville</u>		OR TOWN <u>Baltimore - City</u> (7) X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural give location) <u>1806 Catonsville Rd. 3711 Essex Rd.</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH:	
First (Last) <u>Clara M. Zellers</u>		<u>11 6 1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>WIDOWED</u>	8. DATE OF BIRTH: <u>5-6-1880</u>
9. AGE last birthday: <u>75</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME: <u>George A. Schroeder</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Alice Wolf</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT'S ADDRESS: <u>Charles Zellers - 3711 Essex Rd.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Generalized carcinomatosis</u>		<u>months</u>	
ANTECEDENT CAUSE (S) (B) <u>Adenocarcinoma of uterus</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/5</u> 19 <u>53</u> , to <u>11/6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/6</u> , 19 <u>55</u> , and that death occurred at <u>11/6</u> M. from the causes and on the date stated above.			
alive on <u>11/6</u> , 19 <u>55</u> , and that death occurred at <u>11/6</u> M. from the causes and on the date stated above.			
SIGNATURE <u>S. Wachler</u>		ADDRESS <u>Spring Grove State Hosp. Catonsville</u>	
DATE SIGNED <u>11/6</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 9, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Woodlawn, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <u>Wm. J. Tickner - Secy, Inc., Balto., Md.</u>	
24. FUNERAL DIRECTOR		ADDRESS	

Baltimore

Spring Grove State Hospital

Clara

X.

Hauswife

George A. Schneider

Mr.

Baltimore - City

1806 Campbell Rd.

2-6-1880

73

11

Maryland

Mary Alice Wolf

Charles Sellers - 3711 1/2 St. Rd.

American

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10638

10632 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Balto.</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>607 Baltimore Ave</u>				STREET ADDRESS <u>607 Baltimore Ave</u>	
3. NAME OF DECEASED (Type or Print)		(First) <u>John</u> (Middle) <u>A.</u> (Last) <u>Zimmerman</u>		4. DATE OF DEATH <u>Nov. 7, 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov 22, 1891</u>	9. AGE last birthday <u>63</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Health</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles H. Zimmerman</u>		14. MOTHER'S MAIDEN NAME <u>Clara H. Bonkard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No. <u>—</u>		17. INFORMANT AND ADDRESS <u>Grand N. Zimmerman 607 Baltimore</u>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause <u>331X</u>				(a) <u>Cerebral Vascular Accident (Hypertension) 12 minutes</u>	
Antecedent cause(s)				(b) <u>Hypertension</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last				(c) <u>—</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, or office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 11/50, 1953, to Nov. 7, 1955, that I last saw the deceased
alive on Nov. 7, 1955, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)		DATE <u>11/10/55</u>	NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>	LOCATION (City, town, or county) <u>Balto.</u>	(State) <u>md</u>
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE <u>John H. Sedlack M.D.</u>		24. FUNERAL DIRECTOR <u>Young & Sons 5005 E. Baltimore</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

